HOUSING FOR THE FRAIL ELDERLY

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MAY 4, 1989, AND JULY 26, 1989

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HOUSING FOR THE FRAIL ELDERLY

THURSDAY, MAY 4, 1989

U.S. House of Representatives,
Select Committee on Aging,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., Room 2261, Rayburn House Office Building, Washington, DC, Hon. James H. Bilbray (acting chairman of the committee) presiding.

Members present: Representatives Bilbray, James, Porter, Skelton, Unsoeld, Crockett, Stearns, Costello, Schuette, Ford, Pallone, Schneider, Kennedy, Bentley, Vento, and Morella.

Staff Present: Manuel R. Miranda, Staff Director; Mary Hanlon, Professional Staff; Valerie Batza, Executive Assistant; Diana Jones, Staff Assistant; Carolyn Griffith, Staff Assistant; and Bernie McShay, Legislative Assistant.

Mr. Bilbray. This hearing by the U.S. House of Representatives' Select Committee on Aging will now come to order. At this time I am going to submit Chairman Roybal's prepared statement for the hearing record, and give my opening statement.

[The prepared statement of Chairman Edward R. Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

I have called this hearing to help respond to the ever increasing need to comprehensively deal with the full long-term care of our elderly. People often fail to realize the critical part that housing plays in our response to the care of our elderly. Today we will examine its critical function.

Hearings of the Select Committee provide us not only with an opportunity to explore the most up-to-date information from the experts in the housing and service area, but they allow us an opportunity to stop and remember the elderly, who built this Nation for us, and to reflect on how we chose to care for them.

The majority of the frail elderly are women, living alone, with few relatives to care for them. These people worked hard to care and provide for us and it is our turn to decide how we will care for them.

This hearing on linking housing and services for the frail elderly is at the core of every issue of this Nation. It deals with housing, services, health care, income and dignity.

We must decide:

Will we coordinate our national policy and create a cost effective, integrated means to allow people to remain independent, or will we sit back until we are so far beyond meeting the need that the cost of nursing home care stops the Nation from functioning.

In 1985 nursing home care cost this Nation $36 billion, $19 billion in public funds. By 2030 the aging population will nearly double, and the costs will rise as well.

The Nation is falling sharply behind in caring for the frail elderly. There is a drastic difference in levels of care available for the elderly.

Due to lack of services linked with living arrangements, close to one quarter of the elderly are inappropriately placed in nursing homes.

We must begin to seek out and respond to cost effective, dignified solutions. These solutions do exist.

We have done studies; we have sponsored demonstration programs; we know what works, and what needs to be done.

Today we will hear testimony from four very qualified witnesses. These people will explain for us, one more time, the need, the alternatives, and the savings—both fiscal and social. They will explain to us the barriers and the costs of not responding.

We hope to establish who is caring for the frail. We must not forget the housing managers and sponsors of elderly housing who have become not only building managers but also care takers. Many elderly are "aging in place" in Federal and State subsidized housing, and their needs are not being met.

Housing managers are prepared to handle aging buildings, but not aging people.

I will introduce legislation which beings to develop the link from housing to services. This legislation begins by removing barriers which keep existing services from being linked to elderly housing.

My legislation keeps in perspective the tremendous budget restraints and still addresses the need. We can make the link and save money. We have a long way to go.

Until we establish a comprehensive Federal policy, I will not stop insisting that we link housing and services and provide our elderly with a dignified, appropriate means to remain independent.

STATEMENT OF REPRESENTATIVE JAMES H. BILBRAY

Mr. Bilbray. Today, the House Select Committee on Aging meets to consider a growing problem in government subsidized housing programs. As the elderly population continues to age, we find more and more that seniors in government subsidized housing need help with the basic daily living functions, such as bathing, dressing, eating and shopping. I have seen firsthand evidence of this in my own district with the Espinosa Terra Senior Housing Project which is located in Las Vegas, Nevada. When the senior housing development opened in 1973, the average resident was 70 years old. Now, 16 years later, these original residents are an average of 86 years old and many of them need assistance with these daily living activities.

Currently, there are very few options to keep these seniors living independently. Seniors who need help with daily living activities are too often placed in nursing homes and are forced to spend down their assets, leaving Medicaid to pay for their care. There are several problems with this approach. First, this approach is costing the Federal Government $19 billion per year in nursing services that Medicaid is paying for. In many cases, not needed. Second, and more importantly, there is the trauma that most seniors undergo when they learn that a nursing home is their only option. When an elderly person enters a nursing home, they may well lose contact with their friends, and they will no longer be able to participate in the social activities of the project where they live. In addition, they lose the dignity of living independently in their own apartment. It is my belief that we, as a society, owe it to our senior citizens to allow them to remain in their homes for as long as they are safely capable of doing so.

We have a distinguished list of four panelists today who will share with us their expertise in this area. It is increasingly clear, using existing Federal programs for seniors, we should be able to integrate the provisions of this daily living services into our Federal housing for elderly. Chairman Roybal will soon introduce legislation to remove the barriers that currently exist between the different Federal agencies so that these services can be provided. The upcoming testimony should provide us with some very needed information to show that when housing and services are linked, we can use Federal dollars more efficiently and improve the quality of life for the elderly in government housing.

Does either Member of the Minority side wish to make an opening statement?

STATEMENT OF REPRESENTATIVE CRAIG T. JAMES

Mr. JAMES. Yes. Thank you, Mr. Chairman, for this opportunity to say a few words. As a new member of the Select Committee on Aging, with this being my first hearing, I just want to express my pleasure and honor at being chosen to serve on a fine panel. As the U.S. Representative from the State of Florida, the State with the highest proportion of aging residents, my desire to serve on the Select Committee on Aging is most earnest and I believe important to this committee and to the seniors of Florida and the Nation.

I am also very pleased about my recent subcommittee assignments, as I will be serving on the Subcommittee on Housing and Consumer Interests, and I am especially interested in this morning's hearing on housing for the frail elderly. This certainly is an important issue.

I want to extend a personal welcome and expression of appreciation to the fine witnesses we are about to hear from. Thank you.

Mr. BILBRAY. Thank you. I have several of my colleagues prepared statements before me, and if there are no objections, I will submit them for the hearing record at this time. Hearing no objections, so ordered.

[The prepared statements of Representatives Florio, Costello, Rinaldo, Regula, Bentley, Lightfoot, and Morella follow:]

"HOUSING FOR THE FRAIL ELDERLY: SUPPORT SERVICES TO FRAIL ELDERLY IN GOVERNMENT SUBSIDIZED HOUSING"
HEARING OF THE SELECT COMMITTEE ON AGING

MAY 4, 1989

OPENING STATEMENT

REPRESENTATIVE JAMES J. FLORIO

CHAIRMAN
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS

Good morning, I am pleased to join the full committee to hear testimony regarding the housing and supportive services needs of older Americans. I congratulate Chairman Roybal for calling this hearing; it is important that the full committee as well as the Housing and Consumer Interests Subcommittee, which I chair, consider the plight of so many older adults who have aged in place and whose supportive services needs have changed. In particular, we must address the needs of the millions of low-income older Americans.

Mr. Bilbray, I also commend you for sitting in for the chairman this morning. As a member of our Housing and Consumer Interests Subcommittee, you are an excellent choice and I know you are very concerned about housing and services for your constituents in Nevada.

I believe that today's hearing will add to the record that our subcommittee has been developing which clearly establishes a need for an increase in the number of units built for the elderly and disabled, and an urgent need to expand supportive services for older Americans. We know from past hearings that supportive services, such as those provided by the Congregate Housing Services Program (CHSP), improve the quality of life for persons who want to remain in their homes. These services can also reduce the enormous cost to society of unnecessary institutionalization. I am committed to working with the chairman and interested members of the House to increase the Federal role in providing supportive services to people in Federal housing projects.

Mr. Chairman, we have been working with the American Association of Retired Persons (AARP) and other groups to develop creative ways to provide more bricks and mortar as well a critical supportive services foundation for older Americans. In fact, I recently conducted a field hearing in Toms River with my distinguished colleague from New Jersey, Mr. Pallone, which addressed the problems of and possible solutions to "aging in place." We found a growing need for home health care and chore services, congregate meals, transportation, and innovative housing arrangements such as home equity conversions, shared housing, and life care communities.

Mr. Chairman, the four witnesses that were selected for today's hearing are truly experts in this area and I am impressed with their written testimony. I would be remiss not to mention that we are particularly fortunate to have Robert Katz, Director of The Housing Research and Development Program at the University of Illinois, here to testify and respond to the committee members' questions. Mr. Katz has been working with the Subcommittee on Housing and Consumer Interests and AARP for over a year on a study of the Federal Government's Section 202 housing program for the elderly and disabled. This study and the analyses will be completed in the near future, and we will be releasing a subcommittee print of the study at that time. I am confident that it will add greatly to our knowledge of the status of housing for the elderly and their supportive services needs.

Mr. Chairman, I look forward to working with you on improving the housing and supportive services programs for the elderly.

OPENING STATEMENT
BY U.S. REP. JERRY COSTELLO
SELECT COMMITTEE ON AGING
MAY 4, 1989
"HOUSING FOR THE FRAIL ELDERLY"

Mr. Chairman, I want to thank you for holding a hearing today on this important issue. There are over 70,000 senior citizens in my congressional district, and many of them are served by these government programs. We must take steps to improve the quality of health care and other services to those who are becoming more frail in their old age and need adequate housing as well.

Certainly, housing is a critical component of care for the elderly. Government subsidized units are home to many elderly who live alone and cannot afford an apartment on their own. Over 600,000 seniors nationwide live in federally subsidized housing, and this number will continue to grow.

There is no doubt that one of the major concerns facing the elderly is their own independence. I can't name one senior citizen that I have met who would prefer to live in housing that is provided by someone else, if they could afford their own housing. However, for those unable to afford their own shelter, we must ensure that proper and adequate care is provided and accessible.

In addition, greater numbers of seniors are 'aging in place.' The elderly who entered this housing are remaining in that housing, and many of them stay for the rest of their life. Mr. Chairman, I look forward to hearing from today's witnesses on this important subject. We must take a closer look at ways to improve services to the frail elderly who live in these housing units.

OPENING STATEMENT OF
U.S. REP. MATTHEW J. RINALDO
RANKING MINORITY MEMBER

HEARING OF THE HOUSE SELECT COMMITTEE ON AGING
"HOUSING FOR THE FRAIL ELDERLY"

MAY 4, 1989

THE PROBLEM WE ARE EXAMINING TODAY--THE LINKING OF SUPPORT SERVICES AND HOUSING FOR THE FRAIL ELDERLY--IS ONE THAT DEMANDS OUR ATTENTION. IT'S NO SECRET THAT OUR AGING POPULATION IS GROWING RAPIDLY. WHAT MANY PEOPLE DON'T REALIZE, HOWEVER, IS THAT THE PERCENTAGE OF **FRAIL** OLDER AMERICANS IS GROWING EVEN FASTER. ONE BY-PRODUCT OF IMPROVING HEALTH CARE AND TECHNOLOGY IS THAT AMERICANS ARE LIVING LONGER, AND, UNDERSTANDABLY, THEY WANT TO LIVE INDEPENDENTLY AS LONG AS THEY POSSIBLY CAN. WE HAVE TO HELP THEM DO THAT, AND TODAY'S HEARING WILL HELP US DEVELOP POLICIES TO MEET THEIR NEEDS.

THE NUMBER OF AMERICANS IN NURSING HOMES INCREASED 17 PERCENT FROM 1977 TO 1985. AMERICANS OVER 85 ACCOUNT FOR ABOUT THREE-QUARTERS OF THIS INCREASE. BY THE YEAR 2000, IF PRESENT TRENDS PERSIST, WE WILL SEE A

50 PERCENT INCREASE IN OUR NURSING HOME POPULATION.

THE TRAGEDY HERE LIES NOT IN THESE NUMBERS THEMSELVES, BUT IN THE FACT THAT THIS IS OFTEN THE ONLY AVAILABLE ALTERNATIVE: UNFORTUNATELY, MANY OLDER AMERICANS ARE FORCED INTO NURSING HOMES PREMATURELY BECAUSE THEY CANNOT ADEQUATELY PERFORM ALL OF THEIR DAILY FUNCTIONS INDEPENDENTLY. WHAT WE HAVE TO DO, AND I HOPE OUR WITNESSES TODAY CAN ASSIST US, IS DEVISE OPTIONS OTHER THAN, ON THE ONE HAND, TOTALLY INDEPENDENT LIVING AND ON THE OTHER, INSTITUTIONALIZATION IN A NURSING HOME SETTING.

IN ASSESSING THIS NEED, IT'S USEFUL TO ILLUSTRATE THE DIFFICULTIES MANY FRAIL ELDERLY PERSONS ENCOUNTER. TAKE THE HYPOTHETICAL EXAMPLE OF AN OLDER WOMAN WHO MOVED INTO GOVERNMENT-ASSISTED HOUSING 10 YEARS AGO AT AGE 65. WHILE SHE MAY HAVE BEEN PERFECTLY ABLE TO LOOK AFTER HERSELF THEN, SHE FINDS THAT NOW, AT AGE 75, SHE NEEDS HELP IN SHOPPING, PREPARING HER MEALS, OR BOTH. THE MANAGEMENT OF THE FACILITY SHE LIVES IN, THOUGH PERFECTLY WILLING TO HELP, IS NOT QUALIFIED OR EQUIPPED

TO HELP HER WITH THESE DAILY ACTIVITIES. IN THE ABSENCE OF A LINKAGE BETWEEN HOUSING AND SUPPORT SERVICES, THE ONLY ALTERNATIVE IS TO PUT HER INTO A NURSING HOME, PROBABLY AGAINST HER WILL AND AT SIGNIFICANT PUBLIC EXPENSE.

ACCORDING TO THE BEST ESTIMATES OF EXPERTS IN THE FIELD, AT LEAST ONE-QUARTER OF OLDER AMERICANS IN NURSING HOMES DO NOT NEED TO BE THERE, BECAUSE THEY DON'T REQUIRE THE LEVEL OF CARE THAT A NURSING HOME PROVIDES. THESE PEOPLE ARE IN NURSING FACILITIES BECAUSE THE ALTERNATIVES ARE NOT THERE FOR THEM TO LIVE INDEPENDENT LIVES WITH MINIMAL ASSISTANCE. WE MUST CREATE ALTERNATIVE SUPPORT STRUCTURES FOR THOSE ELDERLY WHO NEED HELP BUT DON'T BELONG IN NURSING HOMES.

I STRONGLY SUPPORT EFFORTS TO FIND A SOLUTION TO THIS PROBLEM. THE FRAIL ELDERLY ARE AMONG THE MOST VULNERABLE PEOPLE IN OUR SOCIETY, AND WE NEED TO EXPEDITE WAYS TO HELP THEM LIVE THEIR OWN LIVES IN SECURITY AND DIGNITY.

OPENING STATEMENT OF THE HONORABLE RALPH REGULA
16TH DISTRICT, OHIO
SELECT COMMITTEE ON AGING - MAY 4, 1989

Mr. Chairman:

I commend you for your efforts in conducting a hearing on the topic of the frail elderly in federal housing. I share your concern for these people.

It is estimated that for every person living in nursing homes, there are at least two persons living in the community requiring assistance with ADLs (Activities of Daily Living). These are people maintaining their independence through an assortment of public and private assistance. As our population grows older and frailer reaching these persons will become more difficult. If we are to avoid the multi-billions spent annually on nursing home care every effort must be taken to encourage systems that make the most effective use of existing benefits.

Data indicates that the 600,000 elderly currently in federal subsidized housing are older and more frail than when the program began. Elderly eligible for subsidized housing must have less than 50% of the area median income. Most of these people live on less than $300 a month. These are those persons most likely not to receive those benefits to which they are entitled.

It is my judgement that home health care is an essential factor in any action to assist the frail elderly to maintain their independence. The linking of this service to public housing would be the obvious outcome of any federal coverage of such care for the poor elderly.

Unfortunately, consideration of a public program or incentives for private coverage also pose dangers. Congress must offer home health care coverage to the elderly but in a responsible manner. In providing home care we must ensure that neither quality and access be compromised, nor should costs to the beneficiary be burdensome. I am concerned that a rapid and unthought expansion of federal services offers the likelihood of a system plagued by abuse and fraud. Rather than benefiting from the increased benefits the elderly could be victimized through unscrupulous or unfit care.

Most experts agree that the home care industry is not sufficiently developed to cope with the rapid increase in demand for services that would come from increased federal coverage. As the industry grows to meet the additional demand shortage would occur in certain areas making it difficult to obtain services. In many cases the care given would be substandard because of poorly trained care givers and inefficient administration.

One solution would be to implement a major demonstration project that could structure a permanent program similar to the procedure used in establishing Medicare's Prospective Payment System.

In sum, Congress should re-examine the spectrum of benefits offered to the elderly and determine what can be done to better coordinate the delivery of such services in an integrated fashion. I look forward to the comments of our distinguished panel on this important issue.

OPENING STATEMENT
BY THE
HONORABLE HELEN DELICH BENTLEY FOR
THE SELECT COMMITTEE ON AGING
ON
"SUPPORT SERVICES FOR THE FRAIL ELDERLY IN GOVERNMENT SUBSIDIZED HOUSING"

May 4, 1989

As we move into the 20th century, the question of services for the frail elderly will certainly burgeon. In this light, I would like to thank the Chairman for holding this hearing today.

Although Government must not replace the family as the predominant source of caregiving, we must take the initiative and include caregiving for the frail elderly in our overall health agenda for this nation.

As we continue to find fault with Medicare and as private health insurance premiums go through the roof, I think we will be forced to take a second look at our health care delivery system. Included in any second look must be a plan to care for the frail elderly.

As an example of what we will face on a much larger scale in the future, a frail couple called upon my office asking where they could live. The wife could no longer care for her husband. He was heavy and cumbersome and she was too weak. Their family could not, or would not take them in, but the family did manage to find them a nursing home. Needless to say, the couple absolutely despises the nursing home and the family fears it will kill them.

This is a sad, but common story. With a few services they may have been able to live in elderly housing. But, on the other hand, maybe the relatives should have taken the couple into their home. It is a tough choice, but one that will come under intense scrutiny as we fight to put our parents, grandparents into limited nursing home spaces and congregate care facilities.

# # #

Jim Lightfoot

HOUSE SELECT COMMITTEE ON AGING HEARING
"HOUSING FOR THE FRAIL ELDERLY"
STATEMENT BY CONGRESSMAN JIM LIGHTFOOT
MAY 4, 1989

MR. CHAIRMAN, THANK YOU FOR HOLDING THIS HEARING TODAY ADDRESSING THE ISSUE OF ADEQUATE AND AFFORDABLE HOUSING FOR THE ELDERLY. RECENT TRENDS INDICATE THE NUMBER OF OLDER AMERICANS WILL CONTINUE TO RISE, NECESSITATING THE NEED TO PROVIDE ADEQUATE SERVICES AND HOUSING ALTERNATIVES FOR THOSE OLDER AMERICANS WHO WANT TO REMAIN INDEPENDENT AND IN THEIR HOMES. HOWEVER, FOR THE FRAIL ELDERLY, THOSE IN NEED OF SPECIAL ASSISTANCE, SPECIALIZED FACILITIES WITH SUPPORTIVE SERVICES CAN OFTEN DELAY OR PREVENT NURSING HOME CARE. A NUMBER OF ELDERLY HAVE BEEN INAPPROPRIATELY PLACED IN NURSING HOMES BECAUSE OF THE LACK OF HOUSING SUBSTITUTES AVAILABLE TO MEET THEIR EXISTING NEEDS.

THE OLDER AMERICANS ACT STATES THE ELDERLY ARE ENTITLED TO SUITABLE AND AFFORDABLE HOUSING. THE PRIMARY TOOL FOR IMPLEMENTING THIS GOAL HAS BEEN IMPLEMENTATION OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT SECTION 202 HOUSING PROGRAM. THE NUMBER OF ELDERLY LIVING IN FEDERALLY SUBSIDIZED HOUSING AND SECTION 202 HOUSING IS OVER 600,000.

THE FEDERAL DEFICIT PREVENTS US FROM RELYING SOLELY ON THE FEDERAL GOVERNMENT'S ASSISTANCE TO MEET THE NATION'S LONG-TERM CARE NEEDS. THEREFORE, I AM PLEASED THAT A NUMBER OF

INITIATIVES HAVE BEEN INTRODUCED TO MEET THE EXISTING NEEDS OF THOSE CONSTITUENTS RESIDING IN MY DISTRICT. ONE PARTICULAR RETIREMENT COMMUNITY THAT COMES TO MIND IS IN THE PLANNING STAGES IN INDIANOLA, IOWA. THIS PARTICULAR CONTINUING CARE RETIREMENT COMMUNITY HAS BEEN DESIGNED TO MEET A WIDE RANGE OF LONG-TERM CARE NEEDS.

THE RETIREMENT COMMUNITY WILL PROVIDE OLDER AMERICANS WITH FOUR HOUSING ALTERNATIVES: INDIVIDUAL APARTMENTS OR TOWNHOMES, LIMITED ASSISTANCE SERVICES FOR OLDER AMERICANS WITH HEALTH OR MOBILITY PROBLEMS, A HEALTH CENTER SUPERVISED BY NURSING PERSONNEL, AND A SKILLED NURSING FACILITY.

MR. CHAIRMAN, I LOOK FORWARD TO OUR PANEL'S TESTIMONY ON GOVERNMENT SUBSIDIZED HOUSING AND SUGGESTIONS AS TO HOW TO PROVIDE HOUSING AND SERVICES FOR THE ELDERLY TO KEEP THEM INDEPENDENT.

OPENING STATEMENT
HON. CONSTANCE A. MORELLA
MAY 4, 1989

Constance Morella

MR. CHAIRMAN, THANK YOU FOR SCHEDULING TODAY'S HEARING TO EXAMINE HOUSING LEGISLATION FOR THE FRAIL ELDERLY.

THERE IS A CLEAR NEED TO PROVIDE BETTER SERVICES TO THE FRAIL ELDERLY WHO ARE LIVING IN SUBSIDIZED HOUSING. I COMMEND YOU, MR. CHAIRMAN, FOR RECOGNIZING THIS NEED AND DEVELOPING LEGISLATIVE SOLUTIONS TO ADDRESS THE PROBLEM.

I LOOK FORWARD TO HEARING FROM OUR WITNESSES TODAY REGARDING COST-EFFECTIVE WAYS OF PROVIDING THE SERVICES NECESSARY TO ALLOW THE ELDERLY TO CONTINUE TO LIVE INDEPENDENTLY.

Mr. BILBRAY. At this time, we have four witnesses, and I will introduce each.

Robert D. Katz, Professor, Director, Housing Research and Development, University of Illinois, Urbana. Mr. Raymond J. Struyk, Director, International Activities Center, The Urban Institute, Washington, DC. Mr. Richard Ladd, Administrator, Senior Services Division, Oregon Senior Services, Salem, Oregon. Stephen Somers, Ph.D., Senior Program Officer, Robert Wood Johnson Foundation, Princeton, New Jersey.

I would ask that we start with Mr. Katz, then Mr. Struyk, then Mr. Ladd and then Mr. Somers, and that we will delay questions for the witnesses until we have completed all testimony. Let us start with Mr. Katz.

STATEMENT OF ROBERT D. KATZ, DIRECTOR AND PROFESSOR, THE HOUSING RESEARCH AND DEVELOPMENT PROGRAM, UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Mr. KATZ. Thank you, Mr. Chairman. I have been asked to address the committee as an individual who has been actively involved in the housing needs of the elderly for the past 20 years. In my capacity as director of a research program at the University of Illinois at Urbana-Champaign, I have participated in a number of national studies, worked with Illinois State Housing officials, and provided technical assistance to local public and nonprofit developers and managers of elderly housing facilities. Issues of aging in place are now a major concern throughout the United States and calls for renewed Federal initiatives in federally funded housing for the elderly are widespread.

In my testimony today, I am going to comment on a national study of Section 202 elderly housing nearing completion at the University of Illinois. Prior studies concerning comparative costs of congregate housing and nursing homes, addition of congregate services to existing elderly public housing, and will present my recommendations for future Federal programs for the frail elderly in federally assisted housing. In addition to my written statement for the record, I would also like to include copies of some of the prior research reports on the subject that were prepared by my staff at the University of Illinois.

With the cooperation and support of this committee's Subcommittee on Housing and Consumer Interests, and with funding from the American Association of Retired Persons, Leonard Heumann and Kathy Gayda from our research group have been conducting a national survey of all the Section 202 elderly projects in the U.S. This study has a number of objectives, including:

One, examination of aging in place and needs for supportive services;

Two, examination of the impact of HUD policies on the development and management of 202 projects; and

Three, provision of a factual basis for deliberations on housing and long-term care needs of elderly, such as the efforts of this committee.

While the 202 study is still in the stage of final preparation, the survey and analysis of data have been completed and some findings can be reported today. First a few words about the scope of the study. A detailed survey instrument was prepared for distribution to the managers of all Section 202 housing sites in the U.S. and mailed out accompanied by a letter from former Representative Bonker, who was chairman of the subcommittee. Follow-up letters were sent to nonrespondents and a total of 3,206 deliverable surveys made up the universe. Of these, we received 1,929 returns or a 60.2 percent response rate. In addition to the issues mentioned above, the survey was designed to permit some longitudinal analysis of a 1983 national study of 202 projects and also to determine the impact of changes in the 202 program since its inception — 1959–74, initial period; 1975–84, Section 8 added; 1985–present, cost containment period.

With respect to congregate service needs of the elderly, the 202 study shows the following:

One, the mean age of residents as reported by 202 managers in 1988 was 73.7 years. When the data was analyzed longitudinally and controlled for facilities built prior to 1983, it revealed that the average age of residents rose by 3.2 years betweeN 1983-88—clear evidence of aging in place;

Two, of the responses we received, only 6.5 percent of all 202 projects for the elderly are congregate facilities providing assisted independent living with the availability of at least five hot meals per week and on-site housekeeping services;

Three, the older the facility, the more residents there are that receive supportive services, and the more likely that the project has made the necessary adaptations that will allow residents to age in place;

Four, sponsors of facilities built prior to 1974 are four times more likely to help fund meal preparation costs than sponsors of more recent developments. Again, evidence that as projects age, so too do the residents and service needs predictably increase; and

Five, whereas longitudinal analysis of our data with data from the 1983 study shows that there has been an increase in the percentage of pre-1983 projects offering meal programs, from 32.8 to 34.8 percent, the overall rate has declined to 25.6 percent.

Because of the very low percentage of meal programs in projects built since 1984, what should be of concern is that in 55 percent of all the projects built since 1984 when cost containment went into effect, HUD reduced the community and/or congregate space proposed by the sponsor.

Where will the meals be served when they are needed in the future? In discussing service needs of the elderly, an on-site meal program is generally cited as the most critical support element to allow the frail elderly to continue to live independently because shopping, cooking and clean-up for meals involve most of the motor functions and mobility skills that are likely to deteriorate as we age. A 1986 study that was conducted in Britain in sheltered housing for the elderly, similar to Section 202, revealed that with respect to the medical problems faced by tenants, 12 percent can be attributed to the lack of a cooked meal daily.

The current 202 study follows on the heels of prior research carried out by the staff of the Housing Research and Development Program (HR&D) concerning congregate service needs and reported by Leonard Heumann at a 1987 hearing of this committee's Subcommittee on Housing and Consumer Interests. In 1985, the Illinois Housing Development Authority (IHDA) released an HR&D report, "A Cost Comparison of Congregate Housing and Long-Term Care Facilities in the Midwest". That report, which has been cited many times, concluded that when using the most conservative estimate, congregate housing produced a cost saving of $1,320 per person per year or $195,000 per year for the average-sized congregate facility. These savings do not take into account that most congregate housing was built after 1980, and the long-term care facilities before 1970. When the capital costs and debt service were normalized in 1985, the savings jumped to $4,233 per person per year and $630,000 per year for the average facility.

If the elderly residents in question are public aid eligible and that is certainly true today with occupancy priorities, the cost savings with congregate housing to the State are significant.

The study also reported that, in addition to the quantifiable cost savings, quality of life factors favor congregate housing over long-term care facilities for many persons.

Building on this comparative study, IHDA, the Illinois Department of Public Aid, and the Illinois Department of Aging commissioned an additional study which was also carried out by Leondar Heumann and Kathy Gayda and which resulted in a 1987 publication, "The Retention and Transfer of Frail Elderly Living in Independent Housing". Among the conclusions from that research was that the number of residents at risk of premature institutionalization because of lack of supportive services ranged from 2.5 percent to 18.2 percent, depending on the measure of activities of daily living used to gauge frailty. The study also concluded that conversion to congregate housing is the most appropriate means of extending the ability of elderly residents to live independently. It is also important to note that the inappropriate retention of elderly in their current environments may be a greater problem than premature transfer. Care givers may devote too much attention to those with acute needs and neglect others because, as British researchers Williamson and Farquar have concluded, they "... may feel such strong feelings of loyalty that they feel obliged to accept the burdens of increasing care."

While the staff of HR&D, has been engaged in research on congregate housing, we have also had considerable hands-on experience in the form of technical assistance to public housing authorities in Illinois in the development of new facilities and the retrofitting of older buildings to congregate sites. We have dealt with both traditional public housing as well as Section 8 buildings built and managed by nonprofit corporations which were established by housing authorities. From this work, we have concluded the following:

One, the need to provide congregate services at federally funded elderly housing is widespread and many managers are attempting to provide these services without Federal assistance;

Two, older buildings, as a rule, have adequate community space in which to deliver needed services;

Three, traditional methods of service delivery to the elderly are "client based" rather than facility based even through the latter appears to be more cost effective and will reach more elderly;

Four, public housing and Section 8 elderly housing facilities, with few exceptions, do not have adequate staff on-site with the necessary skills to deal with the increasing frail and dependent residents; and

Five, the aging process results in continuing decline in the ability of many older persons to live independently and federally funded housing facilities that have been converted to congregate living are now realizing the need to add more supportive services beyond the basic packages of hot meals and housekeeping.

Based on this considerable range of experience both as a researcher and one who has worked closely with elderly housing developers, managers, other professionals, for the past 15 years, I offer the following recommendations for consideration by this committee.

One, Congress should fund an expanded or revised congregate housing services program. Not only has it been shown that this program is cost effective, but it enhances the dignity and quality of life for the elderly;

Two, a federally assisted congregate program should be based on matching funding by the States which, like Illinois, are now spending general revenue funds to support elderly in nursing homes, many of whom could live more independently in less costly congregate settings;

Three, Section 202 and other federally assisted housing for the elderly should be built with adequate community space for the delivery of congregate services and to support assisted living;

Four, HUD should revise its regulations so as to accept the staff costs associated with the delivery of facility-based congregate housing services in public housing and other federally assisted housing for the elderly as an allowable expense in operating budgets;

Five, Congress should approve the concept of, and authorize the necessary funding for, "Project Retrofit" as contained in S.566, the Cranston-D'Amato bill; and

Six, the evaluation of project feasibility for all federally assisted housing for the elderly should be expanded to require that applicants include appropriate information with respect to the service needs of the frail elderly, including an identification of what services are projected, where they are to be delivered, and who will provide them. This aspect of feasibility should apply to both new construction as well as modernization of the existing stock and, in addition, should require evidence that housing providers have established linkages with service providers.

Studies conducted by HR&D and those of other researchers have shown the need for congregate services for the frail elderly. The demand is there and is rapidly growing as residents age in place. Our current service delivery systems are inadequate, underfunded and not coordinated. I commend this committee for highlighting these issues and urge you and the Congress as a whole to respond with new leadership and support for appropriate legislation and adequate appropriations.

Thank you, Mr. Chairman.

Mr. BILBRAY. Thank you, Mr. Katz.

STATEMENT OF RAYMOND J. STRUYK, SENIOR RESEARCH ASSOCIATE; AND DIRECTOR, INTERNATIONAL ACTIVITIES CENTER, THE URBAN INSTITUTE, WASHINGTON, DC

Mr. STRUYK. Thank you, Mr. Chairman. I am very pleased to appear before the committee to discuss options for providing support services to frail elderly living in assisted housing and the legislation about to be introduced to strengthen the Federal housing program already serving the elderly.

I will summarize my prepared statement, and I would like to begin with some general observations about the current need for support services and about the record of congregate housing programs, and then address a few specific points of the legislation.

Today, there is a large number of elderly in federally assisted housing at genuine risk of institutional placement. Applying the rate on the share of all elderly needing personal assistance in one or more activity of daily living, one obtains an estimate of 150,000 or more elderly in assisted housing who would be considered to be in this group. For most, institutionalization would be inappropriate since this intensity of services is not warranted. Moreover, the elderly strongly prefer to remain in their community. In sharp contrast, housing providers around the country report the current assistance levels are insufficient to assist those elderly needing services. Hence, this legislation addresses an immediate and major problem in assisted housing.

As of the summer of 1988, nine States were operating congregate housing programs. These programs have in common that they were originated in the past decade, that they are small, each typically assisting a few hundred elderly. For most, a fitting characterization is they are still essentially demonstrations. At the Federal level, we now have about 10 years of experience with the congregate housing services program and some information from the congregate housing demonstration undertaken by the Farmers Home Administration. At the same time, an increasing share of Section 202 and other federally assisted projects are combining housing and support services in ways very similar to congregate programs. Even so, the total number of frail elderly in assisted housing receiving the services they need is probably a small share of the total.

A hard look at the information available suggests that many of these programs could be improved to make them more cost effective in delaying institutionalization. While there is a substantial unmet need by frail elderly, services are often provided to the unfrail, that is those not at genuine risk of institutionalization, and without proper oversight by a service coordinator. In brief, these programs tend to serve too many seniors not really at risk of institutional placement and tend to provide more services than essential. These problems are not unexpected in young programs, but together they have meant that the congregate programs have not scored well in the few rigorous evaluations of their cost effectiveness in delaying institutionalization.

It is absolutely the case that the effectiveness of congregate or other supportive housing should not be judged solely by its ability to delay institutionalization. The higher life satisfaction accorded to participants is obviously very important and highly valued. Nevertheless, many in Congress and the Executive place great emphasis on preventing institutionalization.

The good news is that very substantial improvements in the efficiency of programs combining housing and support services appear possible. Indeed, I believe, for example, that the changes made in the past few years and the rules governing the screening of applicants for frailty and a mix of services provided in the congregate housing services program have made it much more effective.

Based on past work at the Urban Institute, four central features of new programs have become clear:

One, there should be greater control over admissions. A single area wide agent could conduct all eligibility determinations for frailty and assign an initial service package, thereby achieving greater uniformity, implementing a greater degree of training for those making the admission decisions.

Two, give cash budgets to site supervisors. Tailoring, that is, the matching of services needed to those actually provided would be improved if supervisors could buy the services needed from a variety of vendors rather than brokering them from local publicly supported service agencies.

Three, use capitated funding systems to control costs. The present system of primary reliance on obtaining services from local agencies makes it hard for housing sponsors to even know the value of the services they are delivering. Therefore, a capitated payment system coupled with the cash budget provision would add much needed information and discipline.

Four, we need stronger agency oversight. The HUD area offices working with the State and local service agencies should closely monitor the quality of services delivered and whether the essential services are, in fact, being received.

My view is that HUD should take the lead in demonstrating and evaluating joint housing support service programs with these attributes over the next 5 years. We would then have the basis for deciding how to design congregate and similar programs to meet the expanding number of frail elders who will be living in assisted housing in the years ahead.

The legislation soon to be introduced means to improve the current arrangements for delivering support services to frail elderly in federally assisted housing. By expanding the capabilities of projects funded under Section 202, public housing and other programs to provide well-coordinated support services, the provisions of the legislation will significantly augment the total volume of federally assisted housing with congregate housing attributes.

In light of the need for these units, such expansion is clearly welcome. For the first time, the initiatives in this legislation make possible the provision of properly managed combinations of housing and support services outside the formal congregate housing program.

There are, however, several specific aspects of the legislation that may deserve further consideration. First, the act specifies that up to 15 percent of the cost of support services provided at an eligible project can be paid for with funds authorized under the act. Because a very large share of services now provided comes on a highly or fully subsidized basis from local service providers, most projects do not know the total costs of such services. Obviously estimating the 15 percent figure will be difficult. An alternative would be to simply fund 15 percent of the estimated total costs of services for persons of the average degree of frailty on a capitated-person-month basis as an add-on to other operating expenses. In addition to simplicity, this approach gives the site manager a known level of resources with which to work.

Second, on another cost point, it would seem wiser to fund the cost of major modifications of existing units from separate funds for this purpose administered by HUD rather than as part of operating expenses. If funded as part of operating expenses, these costs could make monitoring operating costs over time difficult for both project and HUD staff. This would happen because a project is expected to need such funding for modifications only episodically. Hence, significant year-to-year jumps in operating budgets would be introduced and, each year, determining the appropriate operating budget for the next year would require considerable effort.

Third, in setting out the criteria for selecting among applicants in the Section 202 program, there is no mention of any matching by the States of the Federal contribution for support services. Although many of the in-kind services received by frail elderly in Section 202 and other projects are funded by the States, we know that year-to-year variation in funding can be a problem. Moreover, not all services needed are always available from these providers. True, the Federal funds will help fill this gap, but I would argue for a matching State contribution to lower the need for the intense brokering of services by site coordinators, to increase the ability to match services needed with those provided, and to establish the precedent of joint Federal-State cash funding of services in projects of these types. Thus, the screening process would give priority to applicants who have secured a State cash match of 15 percent of the total cost of services. Applicants with longer periods of guaranteed matches up to 10 years would receive increasingly higher priority.

Finally, I strongly support the idea of an area-wide waiting list which is proposed. It has the desirable feature of expanding the range of options about which the elderly and handicapped have knowledge. I would hope that the rules implementing this provision contain two particular features:

First, the entity maintaining the waiting list would also make the determination of eligibility for receiving support services. Centralizing this function would permit achieving an important degree of uniformity in such determinations and could make a very important difference in the targeting of the limited support services available. With fewer groups making these determinations, it should be possible for HUD to develop a program for training local staff in this area using national standards.

Second, based on information on the degree of frailty and eligibility to receive services, the most frail elderly could be assigned to those facilities offering the greatest level of support in both unit design and services, subject to maintaining a reasonable balance of persons by level of impairment in each project. In short, a better matching of housing resources with needs could be achieved.

I have appreciated the opportunity to comment on this legislation, and I hope its potential for assisting the frail elderly is realized.

Thank you.

[The prepared statement of Mr. Struyk follows:]

Providing Supportive Services to the Frail Elderly in Federally Assisted Housing

by

Raymond J. Struyk

Testimony Presented Before the Select Committee on Aging
U.S. House of Representatives

May 4, 1989

Mr. Struyk is a Senior Research Associate at The Urban Institute. The views expressed are his own and are not necessarily those of the Institute or its sponsors.

I am very pleased to appear before the Committee to discuss the options for providing support services to frail elderly living in assisted housing and the legislation being introduced to strengthen the federal housing programs already serving the elderly. I would like to begin with some general observations about the current need for support services and the record of congregate housing programs, and then address a few specific points of the legislation.

The Need for Supportive Services

Today there is a large number of elderly in federally assisted housing at genuine risk of institutional placement. Applying the rate on the share of all elderly needing personal assistance in one or more activity of daily living (ADL), one obtains estimates of 150,000 or more elderly in assisted housing who would be considered in this group.[1] For most, institutionalization would be inappropriate since this intensity of services is not warranted. Moreover, the elderly strongly prefer to remain in the community. In sharp contrast, housing providers around the country report that current assistance levels are insufficient to assist those elderly needing services. Hence, this legislation addresses an immediate and major problem in assisted housing.

Current Supportive Housing Programs

As of the summer of 1988 nine states were operating congregate housing programs. These programs have in common that they were originated in the past decade and that they are small, each typically assisting a few hundred elderly. For most a fitting characterization is that they are still essentially demonstrations. At the federal level we now have about ten years' experience with the Congregate Housing Services Program (CHSP) and some information from the congregate housing demonstration undertaken by the Farmers Home Administration. At the same time an increasing share of Section 202 and other federally assisted projects are combining housing and support services in ways very similar to formal congregate programs.

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[1] Those at risk of institutionalization are termed the "frail elderly" in the balance of this statement.

A hard look at the information available suggests that many of these programs could be improved to make them more cost effective in delaying institutionalization. While there is a substantial unmet need by frail elders, services are often being provided to the unfrail and without proper oversight by a service coordinator. In brief, these programs tend to serve too many seniors not really at risk of institutional placement and tend to provide more services than essential. To strengthen the programs progress is needed in the following areas:

- targeting: restricting receipt of supportive services to those at considerable risk of institutionalization; especially important is the promulgation and consistent application of reliable screening criteria.
- tailoring: being certain that services needed by participants are obtained but that "extra" services are not provided to them.
- containing costs: because projects obtain most of their services from publicly supported agencies to whom they make small or no payment, project sponsors do not face real budget constraints in providing services.

These problems are not unexpected in young programs. But together they have meant that congregate programs have not scored well in the few rigorous evaluations of their cost effectiveness in delaying institutionalization.

It is absolutely the case that the effectiveness of congregate or other supportive housing should not be judged solely by its ability to delay institutionalization. The higher life satisfaction afforded to participants is obviously very important and highly valued. Nevertheless, many in Congress and the Executive place great emphasis on preventing institutionalization.

The good news is that very substantial improvements in the efficiency of programs combining housing and supportive services appear possible. Indeed, I believe that the changes made in the past few years in the rules governing the screening of applicants for frailty and the mix of services provided in the CHSP have made it a much more effective program (even though no evaluation of the program since the changes were implemented has been undertaken).

The stakes in improving these programs are enormous. Beyond serving the frail elderly in assisted housing better, the successful approaches developed could become models for community-based housing solutions in the overall long-term care system.

Principles for New Options

Based on past work at The Urban Institute, four central features of new programs have become clear.[2]

> **Greater control over admissions.** A single area-wide agent could conduct all eligibility determinations for frailty and assign the initial service package. This would achieve greater uniformity and permit a higher degree of training of those making admission decisions.

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[2] See, for example, the proposed Congregate Housing Certificate Program described in S. Newman and R. Struyk, "Housing and Supportive Services: Federal Policy for the Frail Elderly and the Chronically Mentally Ill." Washington, D.C.: Urban Institute Paper 2199-1A, 1987.

Cash budgets for site supervisors. Tailoring would be improved if supervisors could buy the needed services from a variety of vendors rather than "brokering" services from local, publicly supported service agencies.

Capitated funding system to control costs. The present system of primary reliance on obtaining services from local agencies makes it hard for agencies to even know the value of services delivered; therefore, a capitated payment system, coupled with the cash budget provision, would add much needed information and discipline.

Stronger agency oversight. Department of Housing and Urban Development (HUD) Area Offices jointly with state or local social service agencies should closely monitor the quality of services delivered and whether essential services are being received.

My view is that HUD should take the lead in demonstrating and evaluating joint housing-support services programs with these attributes over the next five years. We would then have the basis for deciding how to design congregate and similar programs to meet the expanding number of frail elders who will be in assisted housing in the years ahead.

Strengthening Current Housing Programs

The legislation being introduced today moves to improve the current arrangements for delivering support services to the frail elderly in federally assisted housing. By expanding the capabilities of projects funded under Section 202, public housing and other programs to provide well coordinated support services, the provisions of the legislation will significantly augment the total volume of federally assisted housing with congregate housing attributes.

In light of the need for these units, such expansion is clearly welcome. For the first time the initiatives in the legislation make possible the provision of properly managed combinations of housing and support services outside of the formal congregate housing programs.

There are, however, several specific aspects of the legislation that may deserve further consideration. First, the Act specifies that up to 15 percent of the cost of support services provided at an eligible project can be paid for with funds authorized under the Act. Because a very large share of services now provided comes on a highly or fully subsidized basis from local service providers, most projects do not know the total cost of such services. Obviously, estimating the 15 percent figure will be difficult. An alternative would be to simply fund 15 percent of the estimated total cost of services for persons of the average degree of frailty on a capitated person-month basis as an add-on to other operating expenses. In addition to simplicity, this approach gives the site manager a known level of resources with which to work.

Second, on another cost point, it would seem wiser to fund the cost of major modifications of existing units from separate funds for this purpose administered by HUD rather than as part of operating expenses. If funded as a part of operating expenses, these costs could make monitoring operating costs over time difficult for project and HUD staff.[3] This would happen because a project is expected to need such funding only episodically. Hence, significant year-to-year jumps in operating budgets would be introduced; and each year determining the appropriate budget for the next year would require considerable effort.

Third, in setting out the criteria for selecting among applicants for the Section 202 Program there is no mention of any matching by the states of the federal contribution for support services. Although many of the in-kind services received by frail elderly in

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[3] Recall that under the new funding arrangement for S.202, operating budgets and subsidies have to be set almost independently of private rents since the S.202 projects will not have debt to amortize.

Section 202 and other projects are funded by the states, we know that year-to-year variation in funding can be a problem. Moreover, not all services needed are always available from these providers. True, the federal funds will help fill this gap. But I would argue for a matching state contribution to lower the need for the intense brokering of services by site coordinators, to increase the ability to match services needed with those provided, and to establish the precedent of joint federal-state cash funding of services in projects of these types. Thus, the screening process could give priority to applicants who have secured a state cash match of 15 percent of the total cost of services; applications with longer periods of guaranteed matches up to ten years would receive increasingly higher priority.

Finally, I strongly support the idea of an area-wide waiting list. It has the desirable feature of expanding the range of options about which the elderly and handicapped have knowledge.

I would hope that the rules implementing this provision contain two particular features. First, the entity maintaining the waiting list would also make the determination of eligibility for receiving support services. Centralizing this function would permit achieving an important degree of uniformity in such determinations and could make a very important difference in the targeting of the limited support services available. With fewer groups making these determinations, it should be possible for HUD to develop a program for training local staff in this area using national standards (based on those in CHSP).[4] Second, based on information on degree of frailty and eligibility to receive services, the most frail elderly could be assigned to the facilities offering the greatest level of support (in both unit design and services), subject to maintaining a reasonable balance of persons by level of impairment in each project. In short, a better matching of housing resources with needs could be achieved.

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[4] If the process for determining who is eligible to receive support services is not resolved in this way, then the legislation should be modified to address this point explicitly.

I have appreciated the opportunity to comment on this legislation. I hope its potential for assisting the frail elderly is realized.

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Mr. Bilbray. Thank you. Mr. Ladd.

STATEMENT OF RICHARD C. LADD, ADMINISTRATOR, SENIOR SERVICE DIVISION, OREGON SENIOR SERVICES, SALEM, OREGON

Mr. Ladd. Thank you, Mr. Chairman, for the opportunity to be here today and testify before you. The staff asked me to comment primarily on the long-term care service delivery system in Oregon, and most of my comments today will be based around that.

The subject you are investigating, the congregate service needs of the frail elderly in government funded housing, is of extreme national importance. The human suffering caused by the archaic and less than enlightened policies of the Federal Government long-term care are well documented. We lag far behind most all other developed countries in the provision of humane and effective long-term care services. You have an opportunity to begin changing these policies, and I sincerely hope that you do so.

In a November 1988 GAO report to this committee, entitled "Long-Term Care for the Elderly: Issues of Needs, Access and Costs", estimate that 6.2 to 6.5 million elderly Americans need long-term care services. It also stated that most of these elderly, perhaps as high as 75 percent, are receiving this care from family or friends or not at all. Most formal long-term care funded by Federal and State dollars, the report noted, is provided in nursing homes.

The November 1988 GAO report estimates that by the year 2020, 14.3 million American elderly will be in need of long-term care services, more than double the present number. The present system of long-term care will break down long before 2020. The cost of providing mainly nursing home care and the continued human suffering indicative of our present system will force policy changes.

The basic problem with our current method of providing long-term care is our propensity to consider aging a disease and to treat it in medically model facilities. That is, nursing homes. According to the recent Health Care Financing Administration's snapshot of nursing homes in the United States, Oregon has the most impaired nursing home population in the country. Yet, even in Oregon, only 7 percent of the Medicaid nursing home population have complex medical needs. Indeed, over half of our nursing home population have no more medical needs than the elderly living in the general population. Long-term care is not a medical problem. It is a social functional problem. The Federal solution to the growing problems in long-term care has been to study it. Although programs like the home and community based care waivers are noteworthy, they do not go far enough and are severely limited by Federal regulations.

The State solution to the growing problems in long-term care has been to try innovative new strategies in service delivery. Oregon, like several States, has shown that solutions are possible. We reorganized one State government in 1981 to allow all long-term care programs for the elderly and disabled to be administered by a single State agency, the Senior Service Division. These programs include the Older Americans Act, Social Security Block Grant Programs, Medicaid Programs, including nursing homes, personal care, home health and home and community based care waivers, and a State only funded home care program, entitled "Oregon Project Independence".

I have included in my written testimony a table of results of the changes from the years 1979 to 1989. The bottom line of that table shows that we will serve almost 1,000 more people and spend $30 million less than if we had not intervened and reorganized our long-term care system in 1981. We achieved these results not only by integrating our system, but also by instituting several major policy changes. These include, starting in 1981, in Oregon, we made nursing home placements our placements of last resort. In 1980, Oregon implemented pre-admission screening for all Medicaid nursing home applicants, and, to date, we have diverted from nursing home placement to alternative placement about 8,000 folks.

In 1982, Oregon implemented the relocation program where each nursing home resident is periodically reviewed for the potential of being able to benefit from an alternative placement. Since 1982, Oregon has relocated from nursing homes to alternative settings about 7,000 people. In 1982, 25 staffs statewide were assigned to develop alternate resources. As a direct result of this action, Oregon has doubled the home care program and increased the adult foster home program, a home-like setting for five or fewer persons, from about 1,500 in 1981 to about 7,000 today. An interesting result of the adult foster home program is that about 70 percent of these placements are used by private paying clients.

In 1983, Oregon implemented the risk intervention program, which uses State funded case managers to locate private fundings of volunteers to provide long-term care services for those who do not qualify for Federal-State funded programs. Oregon has shown that it is not more expensive to provide alternative services, that providing alternative services will not increase the case loads unrealistically and that while long-term care costs will continue to increase, they need not cost as much as current national estimates would indicate.

Oregon does not consider its long-term care system reorganization to be complete, however. At least two additional steps need to be taken before we can face the future growth of the elderly population confident of success without bankruptcy. We presently have a grant from the Robert Wood Johnson Foundation to develop actuarial tables for long-term care insurance and to develop a public-private affordable long-term care insurance policy for State and local employees.

We estimate current long-term care policies to be too focused on nursing homes and to cost three to four times as much as necessary. This is primarily so because of the lack of actuarial data on alternative services and because the risk pool is too narrow. Only the elderly, it seems, are buying long-term care insurance.

Secondly, we are working very hard to fill a gap in our current system. The placement of many persons who do not have medical problems in nursing homes because no other placement can accommodate their needs. Our assisted living program is being designed to fill this gap.

Assisted living in Oregon is an environment where individuals can live in their own apartments independently and receive many of the intermediate nursing care services that they would otherwise have to receive in a nursing home.

Assisted living services are provided to residents in a social model that begins with the premise of looking at people's capabilities and strengths, instead of their disabilities. In the social model, there is an assumption that all individuals should have a right to live independently with respect for their privacy and dignity, free from restraints. The environment of the apartment complex is one where staff are available on a 24 hour basis providing services based on the needs of the residents.

There is also a growing need to link alternative services to government subsidized housing. Most government subsidized housing projects provide no long-term care services to their residents. Such projects consider residents to be living in their own apartments as they would in their own house, and any long-term care services they require should be provided by other Federal, State and local resources. Indeed, many residents are required to move each year in government subsidized housing projects because they have physically or mentally deteriorated to such a degree that they are no longer considered suitable.

We know of several horror stories in Oregon alone where residents of subsidized housing have hid in their apartments because they were afraid of being sent to a nursing home. Progressive operators of subsidized housing projects, such as Michael DeShane of Kirkland Union Manor in Portland, Oregon, are trying to alleviate these problems by working with local and State programs to provide services. It is a sad fact that they presently must do so mostly surreptitiously.

Current Federal laws and regulations are a prime example of sticking one's head in the sand and ignoring a real phenomenon of the elderly. They continue to age and in doing so will eventually need long-term care services. Providing services to allow the elderly to age in place not only makes good moral sense, it makes good fiscal sense. Anything Congress could do to provide funding for services or even allow existing project funds to be used for services in subsidized housing, and to provide funds to coordinate services with other government programs would be a major step in the right direction.

Such action would recognize the needs and the wishes of those who reside in these projects, to remain in familiar settings as long as possible. Such action may well start a new Federal philosophy concerning long-term care. A philosophy that would put humanitarian concerns above or at least equal to fiscal concerns.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Ladd follows:]

TESTIMONY OF
RICHARD C. LADD
OREGON SENIOR SERVICES DIVISION
BEFORE THE
HOUSE SELECT COMMITTEE ON AGING
EDWARD R. ROYBAL, CHAIRMAN

I would like to thank the committee and Chairman Roybal for the opportunity to testify before you today. I hope my testimony answers all of the questions you asked me to report on in your invitation. The subject you are investigating, "the congregate service needs of the frail elderly in government funded housing," is of extreme national importance. The human suffering caused by the archaic and less than enlightened policies of the federal government on long-term care are well documented. We lag far behind most all other developed countries in the provision of humane and effective long-term care services. You have an opportunity to begin changing these policies, and I sincerely hope you do so.

BACKGROUND

The November 1988 GAO report to this committee entitled "Long-Term Care For The Elderly; Issues of Need, Access, and Cost" estimates that 6.2 to 6.5 million elderly Americans need long-term care services. It also stated that most of these elderly (perhaps as high as 75 percent) are receiving this care from family or friends, or not at all. Most formal long-term care funded by federal and state dollars, the report noted, is provided in nursing homes.

In 1960, the United States institutionalized 2.3 percent of the elderly population in nursing homes , today we institutionalize about 5.2 percent. Our national policy has been to provide primarily nursing home care, with very little support for homecare or care provided in other congregate settings. Federal agencies have defended this policy by stating that an increase in homecare would cause a vast increase in the number of people utilizing these services (because this is what the elderly overwhelmingly prefer). It is therefore less expensive, they have stated, to provide mainly nursing home care. This phenomenon has been labeled the "woodwork effect," because the elderly would come out of the woodwork to take advantage of alternative services. I and most all of my colleagues around the country consider this philosophy to be not only wrong but immoral.

The November, 1988 GAO report estimates that by 2020, 14.3 million elderly will be in need of long-term care services, more than double the present number. The present system of long-term care will break-down long before 2020. The cost of providing mainly nursing home care and the continued human suffering indicative of our present system, will force policy changes.

The states are already recognizing that something must be done. According to the National Council of State Legislatures long-term care is the top priority of 17 state legislatures this year. Nearly every state is attempting to control nursing home utilization and increase alternative care. Whether or not the federal government considers these policy changes to be cost-effective, the states know that they are, and are proceeding accordingly.

The basic problem with our current method of providing long-term care is our propensity to consider aging a disease and to treat it in medical model facilities: i.e. nursing homes. According to the recent Health Care Financing Administration snapshot of nursing homes in the United States, Oregon has the most impaired nursing home population in the country. Yet, even in Oregon only 7 percent of the nursing home population have complex medical needs. Indeed, over half of our nursing home population have no more medical needs than the elderly living in the general population. Long-term care is not a medical problem, it is a social/functional problem. A quote from a nationally recognized expert in long-term care, Dr. Rosalie Kane of the University of Minnesota helps put this in better perspective:

> "Long-term care consists of those personal care and supportive services needed to compensate for functional limitations....the long-term care services themselves are often unspecialized and untechnical. The functional impairments of older people can be divided into those affecting the ability to do basic personal care (such as walking, bathing, dressing, using the toilet, getting in and out of bed, and eating), and those affecting the ability to manage a household (such as cooking, cleaning, shopping, and managing money)."

Because federal and state governments spend so much on the Medicaid nursing home program, there is very little left for other alternative long-term care services. Social Service Block Grant funds are spent primarily on children programs, with little going towards the care of elderly. Older American Act funds are spent primarily on congregate meals and transportation, with Title III-D reserved for homecare, but this is limited to 5 million dollars nationally. Medicaid Home and Community Based Waivers, authorized by Congress in 1981, spent less on alternative services nationally in 1985 than the New York City

Personal Care program alone. Personal Care and Home Health Care are Medicaid's largest non-institutional long-term care programs in terms of dollars spent, but these programs are so medically oriented that they fail to meet the needs of many elderly. I am aware of no long-term care services at all being provided through Housing and Urban Development programs.

State and local governments are attempting to fill the gap, and provide alternative services, but their ability to do so is severely limited. The need is too great for their resources, and without additional help from the federal government, we can expect long-term care to continue to deteriorate. Some states, like Oregon, have attempted to reorganize long-term care services, and provide more rational, more social/functional, less expensive alternative services. These attempts have been accomplished despite federal foot-dragging, and at times outright opposition. It is almost impossible, for example, for any state to expand its Home and Community Based Care Waiver program to meet the needs of the elderly: Federal regulations,pertaining to 1915(c) Waivers, require an empty nursing home bed for each person served in alternative settings.

OREGON'S LONG-TERM CARE SYSTEM

Oregon reorganized its state government in 1981 to place all elderly and disabled long-term care services in one state agency: The Senior Service Division. Oregon also allowed, at local option, for all long-term care services to be managed locally by Area Agencies on Aging. Programs under the supervision of the Senior Service Division include: Older American Act programs, Social Service Block Grant programs, Medicaid (nursing homes, personal care, home health, and home and community based waivers), and a state only funded homecare program: Oregon Project Independence. In addition, most local areas of the state contribute local funds toward alternative services.

Oregon also passed in 1981 legislation titled "The State Policy on Aging". This legislation called for placement of individuals needing long-term care in the least restrictive settings that met their social, function, medical and economic needs. The Senior Service Division has designed its service delivery system to meet the goals of the State Policy on Aging.

Oregon was the first state to receive a 1915(c) Home and Community Based Waiver; Oregon is the only state to have an active 1915(d) Home and Community Waiver; and Oregon is among the very few states which serve more people in their own homes than in nursing homes. Table 1 on the next page shows the results to

TABLE 1

Comparison of Actual and Expected* Growth in the Oregon Long-Term Care System for the Elderly and Physically Disabled 1979 to 1989

Program	Monthly Average Cases	Monthly Average Cost Per Each Case	Total Expenditures
	Actual Expenditures in 1979		
"1979"			
Nursing Homes	8,079	550.33	53,353,393
Federal-State Supported Community Based Care	3,412	123.02	5,036,931
State Only Community Based Care	2,750	51.32	1,693,565
Total	14,241	351.59	60,083,889
	Expected Expenditures in 1989 Without Intervention		
" 1989 "			
Nursing Homes	10,992	1,035.37	136,568,397
Federal-State Supported Community Based Care	4,642	277.47	15,457,050
State Only Community Based Care	3,741	90.33	4,055,669
Total	19,376	671.30	156,081,117
	Actual Expenditures in 1989		
" 1989 "			
Nursing Homes	7,321	1,089.87	95,746,995
Federal-State Supported Community Based Care	7,205	292.08	25,252,834
State Only Community Based Care	3,896	95.09	4,445,529
Risk Intervention Care	1,800	0.00	0
Total	20,222	516.95	125,445,358

* Expected equals the growth rate of the population age 75+, and assumes the cost per case would have been 5% less than the 1989 activity and represents an estimate of conditions that would probably exist in 1989 had not interventions been made in the Oregon Long-Term Care system.

date of Oregon's reorganization of long-term care. The table shows actual caseloads and expenditures in 1979 compared to actual and expected (without intervention) caseloads and expenditures in 1989. The bottom line shows that in 1989 we will serve almost 1,000 more people and spend more than 30 million dollars less, than if we had not intervened and reorganized our long-term care system in 1981.

Oregon has accomplished this enviable record by implementing several different policies.

- Starting in 1981, Oregon made nursing home placement our placement of "last resort."

- In 1980, Oregon implemented Pre-admission Screening for all Medicaid nursing home applicants, and to date have diverted from nursing home placement to alternative placement about 8,000 persons.

- In 1982, Oregon implemented the relocation program, where each nursing home resident is periodically reviewed for the potential of being able to benefit from an alternative placement. Since 1982, Oregon has relocated from nursing homes to alternative settings about 7,000 persons.

- In 1982, 25 staff statewide were assigned to develop alternative resources. As a direct result of this action Oregon has doubled the homecare program, and increased the Adult Foster Home program (a home like setting for 5 or fewer persons) from about 1500 in 1981 to about 7,000 today. An interesting result of the Adult Foster Home program is that 70 percent of these placement are used by private paying clients.

- In 1983, Oregon implemented the Risk Intervention program, which uses state funded casemanagers to locate private funding and volunteers to provide long-term care services for those who do not qualify for federal and state funded programs.

Oregon has shown that it is not more expensive to provide alternative services; that providing alternative services will not increase caseloads unrealistically through the "woodwork effect;" and that while long-term care costs will continue to increase, they need not cost as much as current national estimates would indicate.

Oregon does not consider its long-term care system reorganization to be complete. At least two additional steps need to be taken, before we can face the future growth of the elderly population, confident of success without bankruptcy. We presently have a grant from the Robert Wood Johnson foundation to develop actuarial tables for long-term care insurance, and to develop a public-private affordable long-term care insurance policy for state and local employees. We estimate current long-term care policies to be too focused on nursing home care and to cost between 3 and 4 times as much as necessary. This is primarily so because of the lack of actuarial data on alternative services, and because the risk pool is too narrow (only the elderly it seems are buying long-term care insurance).

Secondly, we are working very hard to fill a gap in our current system: The placement of many persons, who do not have medical problems, in nursing homes because no other placement can accommodate their needs. Generally, we always try to provide long-term care services to persons in their own homes whenever possible. When this is not possible (usually because of the need for more than a few hours of supervision each day) we try to make a placement in Adult Foster Homes. An Adult Foster Home placement becomes very difficult when people need night-time care (usually help in using the toilet). It is extremely difficult for one person to take care of four or five residents during the day and also be up several times during the night providing care. Most of these persons then are placed in nursing homes, even though their medical needs may be minimal. Our Assisted Living program is being designed to fill this gap.

ASSISTED LIVING

Assisted Living, in Oregon, is an environment where individuals can live in their own apartments independently and receive many of the intermediate nursing care services that they would otherwise have to receive in a nursing home. Assisted Living services are provided to residents in a "social model" that begins with the premise of looking for their capabilities and strengths in day to day activities. In this social model there is an assumption that all individuals should have a right to live independently with respect for their privacy and dignity, free from restraints. The environment of the apartment complex is one where staff are available on a 24 hour basis, providing services based on the needs of the resident. The resident, family members and other significant people sit down together to assess what is needed to support the resident in their capacity for living independently.

Assisted Living structurally and programmatically promotes the residents involvement in all decisions that effect their lives, with an emphasis on choice, dignity, privacy, individuality, independence, and homelike surroundings.

The Oregon Assisted Living model was developed by Dr. Keren Brown Wilson of Portland State University, and has been operating for the past five years at Park Place Living Center in Tigard, Oregon. A second center (Regency Park) was developed two years ago by the same company, Milestone Management, in the same area. The Senior Service Division placed 22 medicaid residents, all of whom were eligible for nursing home care, in this facility two years ago to test its ability to provide the care needed to fill our current gap of services. Almost all of these people would have had to been placed in nursing homes were not this facility available.

The results of this test show not only a higher level of satisfaction among these residents, but also a greater improvement of functioning, especially mobility, than we have seen among similarly impaired residents of Intermediate care nursing facilities. We are convinced that Assisted Living can provide the services and meet the needs of at least half of those currently placed in nursing homes, and we are working very hard to expand the program. Senior advocates, frail elderly and their families, many current nursing home operators, and several developers are very interested in Assisted Living.

Currently, in Oregon 10 nursing homes are at various stages of remodeling to Assisted Living, 17 other types of facilities are also remodeling to Assisted Living, and about 48 new facilities are being developed. Because of federal regulations, very few if any of these facilities are using federal housing assistance. We are in the process of changing state regulations to take advantage of this new model, and would greatly appreciate similar changes in federal housing assistance laws and regulations.

It is interesting to note, that while each resident of an Assisted Living facility has their own apartment, the cost of Assisted Living is currently 80 percent of the cost of Intermediate care nursing facilities for both public and private residents. This is true primarily because each resident is expected to do as much for themselves as possible, thereby requiring fewer staff; and because limitations on what staff can perform and when, as required by regulations in nursing homes, does not apply to Assisted Living.

OREGON'S LONG-TERM CARE SYSTEM AS A MODEL FOR THE COUNTRY

Each state has developed its own system of long-term care, dependent on political considerations and resources available. We would not recommend that any state model its long-term care programs in its entirety after Oregon. The Oregon model fits Oregon, but most probably not any other state. Parts of the Oregon model, however, can be adopted by other states, and indeed several have done so. For example, almost every state in the country is expanding (as best they can with limited federal resources) alternative services. In addition, we see Assisted Living being developed in other states at the present time, though it usually does not provide as many services to residents.

We feel, however, that the federal government should take steps to learn what has not only been accomplished in Oregon, but also in several other states, such as Wisconsin, Maine, Arkansas, Washington, New York, and Texas. Several innovative methods of providing long-term care services are being implemented by the states. With the exception of a six state study recently completed by Diane Justice of the National Governors Association (on loan from the National Association of State Units on Aging), the federal government seems to have little interest in state progress. It has been our experience, that most federal agencies, especially the Health Care Financing Administration, hold state innovative efforts in long-term care in low regard, and usually see such innovations as just another way of receiving more federal dollars.

LINKING CONGREGATE SERVICES TO GOVERNMENT SUBSIDIZED HOUSING PROGRAMS

Most government subsidized housing projects provide no long-term care services to their residents. Such projects consider residents to be living in their own apartments as they would in their own house, and any long-term care services they require should be provided by other federal, state and local resources. Indeed, many residents are required to move each year from government subsidized housing projects because they have physically or mentally deteriorated to such a degree that they are no longer considered suitable. We know of several "horror" stories in Oregon alone, where residents of subsidized housing have hid in their apartments, because they were afraid of being sent to a nursing home.

Progressive operators of subsidized housing projects, such as Michael DeShane of Kirkland Union Manor in Portland, Oregon, are trying to alleviate these problems by working with local and state programs to provide services. It is a sad fact that they must presently do so mostly surreptitiously. Current federal laws and regulations are a prime example of sticking ones head in the sand, and ignoring a very real phenomena of the elderly: they continue to age and in so doing will eventually need long-term care services. Providing services to allow the elderly to "age in place," not only makes good moral sense, it also makes good fiscal sense.

Anything Congress could do to provide funds for services (or even allow existing project funds to be used for services) in subsidized housing, and to provide funds to coordinate services with other government programs, would be a major step in the right direction. Such action would recognize the needs and wishes of those who reside in these projects to remain in familiar settings as long as possible. Such action may well start a new federal philosophy concerning long-term care, a philosophy that would put humanitarian concerns above, or at least equal to, fiscal concerns.

Thank you, Mr. Chairman and members of this committee for allowing me to present testimony today.

Mr. BILBRAY. Thank you, Mr. Ladd. Dr. Somers.

STATEMENT OF STEPHEN A. SOMERS, PH.D., SENIOR PROGRAM OFFICER, THE ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NEW JERSEY

Mr. SOMERS. Thank you, Mr. Chairman. It is a pleasure to be testifying before you today on an issue that desperately needs and deserves public attention: the plight of seniors in housing not designed or enriched to serve people as they age in place and become less functionally independent.

I would like to ask that my prepared statement be read into the record so that I can make more informal remarks.

Mr. BILBRAY. Without objection, so ordered.

Dr. SOMERS. Thank you. On a personal note, I would like to point out that this issue has been something of a personal quest for me, too, since I worked for your former counterpart, Senator John Heinz, who then served as the chairman of the Senate Special Committee on Aging.

I must admit that we tried to address this issue in 1984 at a field hearing, and it is gratifying to see that Mr. Roybal will soon put the rather abstract perceptions of our earlier attempts into some concrete legislative proposals. I commend him and his staff for their interests and actions to date. I am afraid I left Washington feeling as though the conceptual gap between housing and services for special needs populations would never be bridged because of the very real and concrete chasms between legislative, budgetary and executive agencies dealing with housing and health policy in this country. I left to go to work for a foundation, the Robert Wood Johnson Foundation, because it promised opportunities to develop innovative ventures that were not necessarily restricted by these same chasms.

Although the differences in training, professional incentives, et cetera, between bricks and mortar houses and social service providers run fairly deep and down to the most practical levels, maybe for me it was the so-called "plumbers" in Section 202 housing, who were coordinating social services on the side, that gave me hope that there would be an eventual resolution of the gaps between housing and services.

In any case, I would like to describe a foundation initiative that speaks to these issues. The Supportive Services in Senior Housing Program is a 10 State effort in which we are working with the National Council of State Housing Agencies and 10 States' housing finance agencies to try and establish self-sustaining supportive services programs in publicly assisted privately-owned housing projects, principally started under the HUD Section 236 and Section 8 New Construction Programs.

The explicit objective of this program was to develop creative ways of financing services for the frail elderly. A unique aspect of the program is its emphasis on leveraging private financing from State and local housing project reserves and from resident fee-for-service payments.

Based on commitments made by the 10 grantees in the application process, we expect to leverage $10 to $15 million with our own

$3.2 million investment. In addition, based on preliminary data from an earlier foundation program, the Supportive Services Program for Older Persons, we believe it is realistic to expect that even lower income older persons will purchase services they know they need in order to remain independent.

Under the Supportive Services Program, we funded visiting nurse associations and home health care agencies to conduct extensive market research in order to design supportive services projects. These agencies are now demonstrating that a private market can be established for elders in the community. The most popular services have been related to maintaining the home environment, usually housekeeping and yard work, lawn mowing, et cetera.

The main point I wanted to make is that 33 percent of the people purchasing services under this program to date have incomes below $10,000. Many of them are closer to $5,000 in annual income.

Our interpretation of this very preliminary data is that older persons want to stay in their own homes; they know what they need in order to remain independent; and they are willing to pay for essential services or, in some instances, to get their adult children to help them pay for such services. I also want to issue a caveat of sorts at this point. We are not arguing that all frail elderly persons have the means or the wherewithal to know what they need in order to avoid institutionalization. Nonetheless, there are two lessons that I think are important.

The first is that we should not remain wedded to the medical model of care in the long-term care area because elderly people are not and do not want to be perceived as cases to be managed. They want to remain independent and sustain a sense of their own autonomy.

Second, with public sector dollars limited, another important lesson is that elderly people will vote with their pocketbooks for needed services.

It remains to be seen whether the same kinds of supportive services programs can be developed in senior housing projects. There are different income levels, different expectations about availability of services and different attitudes about independence in those projects. However, early returns on the market research that is being conducted by these projects are positive and indicate the following:

One, again, case management will be rejected as a service by elderly residents of senior housing projects.

Two, they do, however, feel the need for help in access to gaining access to services.

Three, they would like to be able to purchase housekeeping assistance and transportation.

Building managers and project owners also see the need for some supportive services. The two that they have indicated are most needed are household help for their residents and mental health services. They see a tremendous amount of isolation, alcoholism, dementia, et cetera, among their residents and naturally this scares them.

The projects are now struggling to design combinations of private dollars, that is, the reserve funds and private fees, public services, such as AAA services, 2176 waivers under Medicaid, et cetera, and volunteer services will sustain these projects and these services over the long haul.

I should add that there is a very strong sense among the owners and the residents both that they do not want to be perceived as nursing homes without services nor do they want to become, on the other hand, unlicensed nursing homes.

Before we get too self-congratulatory about the progress we are making on the conceptual and concrete fronts in blending housing and services, we must recognize that our program, the congregate housing services program, and others like it, are "after-the-fact" programs. Services are being inserted into bricks and mortar units that were not designed for the disabled or for service delivery to support the disabled.

In order to really address the problem, there must be prospective integration of housing and services, and this can only be accomplished by blending the financing for housing and services at the outset. There are some models that are now working and/or are being considered:

One. In new moderate income elderly housing projects we already know that services are being provided and that they are being paid for by increasing the sales price of the units, by increasing the condominium fees, or by simply increasing the rents.

Two. Another way of paying for services at the same time as the bricks and mortar is to over-capitalize the development and create "service endowments" generating funding streams that will continue to pay for services over time.

Three. There is the concept of explicitly blending public subsidies for housing assistance and services assistance, such as those being discussed here in Washington now.

The Foundation is very happy to be able to play a part in this discussion. We recognize as with all foundations we cannot do this alone. It will take the best efforts of both public and private sectors to accomplish the objective of creating service enriched housing for special needs populations.

Thank you very much.

[The prepared statement of Mr. Somers follows:]

TESTIMONY
to
U.S. HOUSE SELECT COMMITTEE ON AGING
Edward R. Roybal, Chairman

by Stephen A. Somers, Ph.D.
Senior Program Officer
The Robert Wood Johnson Foundation
P. O. Box 2316
Princeton, N.J. 08543

Mr. Chairman, thank you for inviting me to testify today on integrating services into housing for special needs populations. My name is Stephen Somers. I am a Senior Program Officer at The Robert Wood Johnson Foundation and I have primary responsibility for programs in a wide range of areas including those I am going to discuss today. I have two major objectives in testifying today:

(1) to describe the fundamental features of our efforts to promote integration of services into elderly housing; and

(2) to convey the underlying rationale for our approach to the long-term care issue.

Before I take up those tasks, perhaps I should say a word or two about The Robert Wood Johnson Foundation. For the record, an Annual Report and a recent statement of the Foundation's grant-making strategies by its President, Dr. Leighton E. Cluff, are available for your staff. The Foundation is the country's largest in the health care field and has since its inception as a national institution in 1972 made grants totalling $962 million. The majority of the grants have been for health service demonstration programs. But significant funding has also been directed to training and health services research. Well over $100 million of our grants have supported demonstration programs in the aging arena.

Up until the early 1980s, the rationale underlying many of our demonstrations was to design and implement new models, evaluate them properly, and, if successful, disseminate them for broader replication by the federal government and others in the public sector. For example, we supported some early work on the hospice model, and on HMOs and social HMOs.

Today, however, it is clear that we can no longer rely solely upon public funding for the broader implementation of important social service initiatives. The federal deficit and competition from equally pressing social needs have compelled us to consider other means for beginning to address problems such as the gaps in our nation's system of long-term care. Where possible, we attempt to design demonstration programs that: (a) enable individuals to help themselves; (b) build upon the current system's resources, assuring that available public funds are more efficiently used and targeted to those most in need. The programs I am going to discuss today all strive to meet these objectives.

In general, this nation looks for pluralistic solutions to problems. Because long-term care involves individual needs and preferences regarding living arrangements and life style, and because it calls for a much broader mix of services than does acute care, the pluralistic approach is even more appropriate. Furthermore, because maintaining personal autonomy should be a primary goal of all long-term care programs, we feel strongly about encouraging individuals to exercise choices about desired services.

Of the nearly 30 million older Americans, two to three million live in senior housing complexes constructed with federal assistance. In a number of these complexes, residents' average age is now over 80, yet these projects originally were designed without taking into account the eventual supportive service needs of those with health problems. Increasingly, "bricks and mortar" housing managers face a choice of providing new kinds of supportive services or evicting functionally dependent or health-impaired tenants and thereby forcing their premature institutionalization.

Many frail elderly people can continue to function in their communities if appropriate supportive services are available. The ability of older people to live independently varies widely according to age, income, living arrangements, available services, disabilities, and -- especially important -- the availability of informal care from spouses, relatives, other nonprofessional caregivers. By and large, relatives and friends provide 75 to 80 percent of this care. In senior housing, however, the amount of such informal care appears to be less, and substitutes are vital. Projects in housing developments with large concentrations of elderly could take advantage of economies of scale and provide for more efficient and affordable service delivery.

The Supportive Services Program in Senior Housing (SSPSH) is a $3.2 million national initiative being conducted with the assistance of the National Council of State Housing Agencies and ten (10) state housing agencies across the country (CO, IL, MA, ME, NH, NJ, PA, RI, VA and VT). In recognition of the health and mental health problems associated with "aging in place," the goal of this recently funded Program is to help develop efficient and financially sustainable health service models in publicly assisted, privately owned senior housing projects (funded principally under the HUD Section 236 and Section 8 New Construction Programs).

The explicit objective of this initiative is to demonstrate that housing finance agencies, working with housing project owners and managers and local service providers, can organize and finance necessary services that elderly frail residents want. A unique aspect of this Program is its emphasis on leveraging private financing both from state and local housing project reserves and from resident fee-for-service payments. Based on commitments made by the ten grantees, we expect to raise $10 to $15 million in reserve funds to help pay for services over the life of the Program.

In addition, based on preliminary data from an earlier foundation initiative, the Supportive Services Program for Older Persons (SSPOP), we believe that it is realistic to expect even lower income older persons to purchase services. Under this Program, home health agencies conducted extensive market research in order to design supportive services products and are now demonstrating that a private market for such services can be established for elders in the community. Interestingly, the most popular services to date have been related to maintaining the home environment (e.g. housekeeping, yardwork, etc.). To date, roughly 33 percent of the purchasers have been individuals with annual incomes below $10,000; a significant number have incomes closer to $5,000 per year. Our preliminary interpretation of this data is that:

- older people want to remain in their homes, they know what help they need in order to remain independent, and they are willing to pay for such essential support themselves.

We are not suggesting that all disabled elderly persons at the poverty level can buy all the help they need or even know what special services they need in order to stay out of the nursing home. Nonetheless, these early findings could represent a critical development for several reasons:

(1) we should not be overly wedded to the "medical model" for determining what supportive and long-term care services are needed by the frail elderly. By conducting market research, designing products according to demand, and letting elderly people "vote with their pocketbooks" we may do more to enhance their capacity to be independent than if all the well-intentioned case managers were at their disposal. People clearly do not want to be "cases" to be "managed," and their sense of autonomy seems better served by the opportunity to make service decisions themselves.

(2) because public sector resources are constrained at all levels, it is reassuring to find that many older persons in the community are willing to dig into their own pockets to pay for services.

It remains to be seen whether this same phenomenon will emerge in publicly assisted, senior housing projects. Individual resources may be more limited and some of the home-related services are already built into the project (e.g. repairs, lawnmowing, etc.). Others may be more available than in the general community (e.g. service coordination, meals on wheels).

Returns from early market research in the ten senior housing sites are positive. Again, residents do not want case management. However, there are indications that there will be a demand for help accessing services, housekeeping, and transportation. Housing managers are eager to address perceived needs for household help, and mental health services to combat isolation and lack of community activities. All the projects are still struggling with what combinations of private funds (reserves, fee-for-service payments) publicly available services, and volunteers will best meet the demand. Both residents and management want to avoid being in "nursing homes without services" or becoming "unlicensed nursing homes."

This Program, HUD's Congregate Housing Services Program, and other like-minded initiatives are all facing similar dilemmas -- how to deal with service needs that were not contemplated when the projects were designed and financed. More than 4 million people live in housing (public and private) designated for the elderly and disabled. Typically, it has been built without any consideration given to appropriate design or to service delivery and financing. The result is that the architectural design often actually impedes maintenance of functional independence (e.g., lack of ramps, inaccessible fixtures, etc.).

In addition, services are fragmented and are available only to the extent that residents meet restrictive eligibility criteria for public programs that themselves are subject to the vicissitudes of annual appropriation processes. This situation is attributable to two interrelated phenomena: (1) public-sector budgets for housing and for health and social services are separate items overseen by separate legislative committees and executive agencies. Unless concerted efforts are made to bridge gaps, both conceptual and financial, between housing and health services, we are doomed to face an ever-increasing demographic problem with these after-the-fact, patchwork solutions; and (2) private housing developers and financiers worry about assembling bricks and mortar and the money to pay for construction and building maintenance (they are not trained to factor in service needs or costs). It is apparent that considerable progress is being made on the conceptual front. Supportive or "service-enriched" housing is now on the policy agenda. What remains to be done is to seek out and support innovative financing mechanisms that will make the abstract ideas into a tangible reality for residents of future housing projects for elderly and disabled persons. Fortunately, some progress is being made on this front as well:

- in new projects for moderate income elderly persons, the costs of health-related services can be added into the sales price of a unit, in rental payments, or condominium fees.
- developers can over-capitalize a project to create an "endowment" which will continue to generate funds to pay for health-related

services; and

- public assistance can be combined in such a way as to subsidize both the housing and the health-related services.

As a foundation whose focus is health care, it is somewhat difficult to address these issues alone. However, we are working with other foundations as well as the public sector both to integrate these structural mechanisms for financing needed services into the basic housing costs and to make more efficient use of existing public programs. To date, the response of both the private and public sectors has been promising.

It is gratifying to be in a position to contribute to innovative efforts to blend housing and health services for needy populations. It will take the continued interest and support of leadership in both sectors to make service-enriched housing a viable option in our nation's system of long-term care.

THE VIEWS EXPRESSED IN THIS STATEMENT ARE THOSE OF THE AUTHOR, AND OFFICIAL ENDORSEMENT BY THE ROBERT WOOD JOHNSON FOUNDATION IS NOT INTENDED AND SHOULD NOT BE INFERRED.

Mr. **Bilbray**. Thank you.

The first question will be to Mr. Struyk.

Mr. Somers estimated that there are 2 to 3 million older Americans living in federally assisted senior housing complexes.

Can you give us an estimate of what percent of those seniors may be in need of some kind of services?

Mr. **Struyk**. Well, there are two different concepts on the table here, and I think it is important to distinguish between them.

One group, which is a substantially smaller number, would be a group that would need services, support services, to delay institutionalization. These are people who are really at risk of institutional placement, and, as I said in my testimony, using a rough metric, and the measurement here is not very good, of people who require some personal assistance with at least one activity of daily living, eating, toileting and so on, that number is about 150,000. I think that this is on the order of 8, 9 or 10 percent of those currently in the assisted housing.

The other concept, which is people who need services to live a fuller life but are not actually at risk, is a much higher figure, about 25 percent of the elders in assisted housing.

Mr. **Bilbray**. Dr. Katz and then Dr. Somers, both of you seem to be nodding a little differently.

So, Dr. Katz?

Mr. **Katz**. Well, I would just say that the study we did in Illinois, and I suspect the population in Illinois is not that different from other States and in our study looked at all the assisted housing in Illinois, we came up with somewhat higher figures than Mr. Struyk has indicated.

However, I agree with him. It depends how you measure activities of daily living, but we found that, up to 18 or 19 percent of the population is at risk, and that includes only those people who are currently living in assisted housing.

If you factor in also those who are not now living in assisted housing, and our study included those,—

Mr. **Bilbray**. And need to be is what you are saying?

Mr. **Katz**. Pardon?

Mr. **Bilbray**. And need to be.

Mr. **Katz**. And need—well,—

Mr. **Bilbray**. Or need the assistance.

Mr. **Katz**. Who need assistance. That is people who are welfare recipients who are not living in assisted housing and just the fact of living in assisted housing is some kind of a desirable environment. Of those persons living alone in their own homes, the figure is higher. We found up over 20 percent of those population in Illinois were in that situation.

So, I think the figures are high and with our aging population, I can only project they are going to continue to increase.

Mr. **Bilbray**. Thank you.

Dr. Somers?

Dr. **Somers**. I agree with Mr. Struyk that there needs to be a distinction made between those who are at risk of institutionalization and those who are merely looking for supportive services to enable them to lead fuller lives.

I would imagine that everyone would like to have supportive services of one sort or another. In fact, I could use a case manager myself sometimes, but those who are truly at risk of institutionalization is a smaller number. I would not argue with Mr. Struyk about the percentage. I suspect that they are 10-15-20 percent, somewhere in that range.

Mr. BILBRAY. So, you agree with both then, 10-15-20 percent?

Dr. SOMERS. I would like to agree with the experts on the panel, yes.

Mr. BILBRAY. I would like to get into the Oregon plan a little bit. But first, at present our figures show that there are approximately 62 complexes, federally funded congregate housing service programs, handling about 2,000 people in the country.

Is that the kind of figure you have, also, do those programs provide the services that we are talking about in this bill?

That is open to anybody. CHSP Program, about 62 complexes in the country?

Mr. STRUYK. Right, and providing services to something on the order of 1,600 elderly.

Mr. BILBRAY. 1,600 to 2,000. And, now, Mr. Ladd, in Oregon, you say you saved about $30 million by providing your type of program.

Could you give us a little more background, what it costs for the nursing home and what it costs for the individual person to be housed under your program, and what you provide exactly?

Mr. LADD. Yes, I can, Mr. Chairman.

The graph I have in my written testimony showed that in 1979, we had 8,079 folks in the Medicaid program in nursing homes. The average cost in 1979 was $550 a month, and we had 3,400 people receiving Federal-State combined home care, mostly through the Social Security Block Grant or what was called Title XX in those days, and in our State program, about 2,700.

What we did was try to control nursing home utilization and build the alternative. We concentrated on that, as I said in my comments, and made nursing homes our placement of last resort.

Today, we have lowered that 8,079 figure down to 7,321 in nursing homes, and we have increased the services primarily through the 2176 Home and Community Based Care Waiver Program—although we presently have the only 1915D Program that was passed as part of the Reconciliation Act a couple of years ago—and we have 7,200 folks being served in these programs.

We expect by late this year to be serving more people in their own homes through Medicaid funds than we are serving in nursing homes. When we reach that point, we will be the only State to be in such a position.

Mr. BILBRAY. What is the cost of in-home service on an average basis?

Mr. LADD. The cost, on the average, for the in-home service is $292.08 a month.

Mr. BILBRAY. Okay. Now, you gave me a 1979 nursing home figure. Do you have any update as to what it would cost now?

Mr. LADD. Well, the cost for in-home service is $292.08 a month.

Mr. BILBRAY. Right.

Mr. LADD. The cost for a nursing home today is double what it was in 1979. It is $1,089.87 a month. So, obviously providing home care is about a quarter of what it costs to provide nursing home care.

Mr. **Bilbray**. Okay. Now, being the devil's advocate, if I was arguing against you, I would say, what percentage of those people that you are providing the in-home services to would be in a nursing home if you did not provide it versus how many of them would be not living as well as they should and certainly not providing as good of services as we should? What do you figure? Half of them? A third?

Mr. **Ladd**. That is a difficult question to answer, Mr. Chairman. We do know that every one of those people receiving home care are at the same impairment level that would qualify them for services in nursing homes.

We do know that before we put this in place, we did surveys of people in the field and a lot of people that were impaired, highly impaired, told us we surveyed them and did functional studies on them, and we had a thing called "The Spunk Factor".

The Spunk Factor is some old guy saying "I don't care how impaired I am, I ain't going to that nursing home". As a consequence of the type of living—

Mr. **Bilbray**. My mother.

Mr. **Ladd**. —that they see in a nursing facility. So, it is very difficult to say how many of those people would be in nursing homes had we not had this in place.

Our estimate is that we would have 10,992 in nursing homes today, and that is simply an estimate based on the population increase assuming that the same percentage of people who were in nursing homes, the population who were in nursing homes in 1979 would be in nursing homes today.

We have worked with the State of Colorado quite a bit. Colorado started out in 1979 about where we were in nursing homes, and today have about 11,000 folks in nursing homes. So, we assume that the same thing would have happened in Oregon had we not intervened in that system.

Mr. **Bilbray**. Does anyone want to come in on that? Make any comment on that? Mr. Katz?

Mr. **Katz**. One comment. While I agree that there is substantial cost savings, and in my testimony I mentioned some data for Illinois, we should not neglect the fact that there are some other aspects that are not easy to quantify and which favor a congregate setting. One piece of data that we have, which is, I think, useful here is the fact that in the average congregate housing each resident now has about 400 to 500 square feet in a private apartment and that compares with 100 to a 150 square feet of semi-private space around a bed in a nursing home.

So that when you are looking at comparisons, you have got to look at these quality of life factors and, clearly, that is a significant factor in our analysis of why we would favor congregate housing for those who can live independently.

Mr. **Struyk**. If I could just build on something, and Mr. Ladd may want to correct me, but the truly important point is that Oregon does a very careful job, a very thorough assessment job on everybody in this pool, both those receiving at-home care and those in institutions.

The big cut, the more important cut, is the screening itself, getting into that pool at all, and most—many places at least—are not doing a very good job. So, the targeting in Oregon is probably quite good in terms of delayed institutionalization compared to a lot of other States, and it is because they do such a careful job on assessment; some of their procedures are really models for other States.

We looked at five States last summer, and Oregon was really exemplar in the care with which they did assessments. This is where the initial really big improvement can be to targeting.

Mr. **Bilbray.** Thank you.

Dr. Somers?

Dr. **Somers.** In listening to the comments of my fellow panelists, I would just caution that it is very hard to prove a direct linkage between increased home services and a delay in institutionalization. There are too many other factors that can intervene. I would, however, add that in a recent discussion of "out-of-control" national health care costs, former Secretary Califano indicated that delaying nursing home institutionalization is one of the major areas where we could save significant funds. If we could delay it by 1 or 2 weeks, for each person institutionalized we could save billions and billions of dollars over the course of years.

Mr. **Bilbray.** Very good.

I have other questions, but I am going to pass to my colleagues so they have an opportunity.

Mr. Schuette?

Mr. **Schuette.** Thank you very much. I appreciate your courtesy.

Gentlemen, thank you for your comments and the statements you have submitted to us.

Mr. Ladd, if I may and notwithstanding my pride coming from Michigan, I have a sister who lives in Oregon. So, your comments intrigued me.

Whether it is for the frail and infirm, or those elderly who may in the future have a moment of frailty, what suggestion would you have for this committee with respect to options prior to nursing home care? Do you have suggestions in the home health care field in terms of helping people stay well and before one must provide the means to support for those who are ill?

And, secondly, what type of incentives from the government would be the most beneficial? I am thinking of options such as a health care retirement account or being able to utilize insurance funds for nursing home care or home health care. What type of attraction do you find in terms of these types of government incentives?

So, two questions. What other services can be provided prior to nursing home care to keep people well, and what do you think about incentives in the Tax Code in terms of diverting funds either from an employer-paid retirement program or from insurance proceeds to help in maintaining their wellness?

Mr. **Ladd.** On the first part of your question, there are a number of things that we can do without cost that would allow States the flexibility of setting up long-term care systems to deliver the types of services that people want.

I have been the Aging Director for the State of Oregon now 10 years. In that capacity, I have talked to a lot of seniors, probably most of them around the State, and I have yet to run into a senior who said when they needed long-term care they wanted to go to a nursing home to get it. Without exception. One senior over in Baker, which is a small town in eastern Oregon, said he wanted to go to a nursing home when he needed long-term care, preferably that would be the nursing home that he owned.

They do not want to have this type of care. The Federal regulations, however, favor nursing home care, have for years. There is the institutional bias. Most of the services for long-term care are paid through Medicaid.

It is easy for a State to double their nursing home population any time they want to as long as they have got the State match and the Federal Government does not question this. They just put the money out. Try to add 10 home care slots to your program and you are in for a fight that takes you a year or two to get approval for.

If we could just lessen the Federal regulations, especially the Medicaid program, and offer home care services—

Mr. **SCHUETTE**. How would you relax them, Mr. Ladd?

Mr. **LADD**. Well, for one thing, 1915C or 2176 Home and Community Based Care Waivers are probably the most innovative thing the Federal Government has done in a long time, they came from the 1981 Reconciliation Act.

The law is fairly specific. The law says that you can use Medicaid funds to provide home care as long as in the aggregate you do not spend more money than you would in the nursing facility.

The regulations, however, say that for every person that you serve in the community, you have to have an empty nursing home bed. The theory of the regulation is saying that obviously if you lose your waivers, they have got to have some place to go: a nursing home.

Well, how that translates to the State is: in order to increase the number of people we are serving in the community, what we would have to build a bunch of nursing homes and keep the beds empty. So, it is self-limiting. It is a case where Congress, who had the foresight to pass the law, looking for something happening, HCFA got the regulations and decided that that was too liberal and they wanted to cut back on it.

So, we are constantly being harassed, and roadblocked from having the flexibility to develop these programs ourselves. Every State or most every State has used their State only funds, free from Federal regulations, to try to develop this stuff, but no State has the resources to do this alone. It has to be a partnership with the Federal Government.

Mr. **SCHUETTE**. How do you react to the second portion of my question, sir, with respect to Federal incentives and tax changes, given the tremendous budget constraints in terms of home health care coverage?

Mr. **LADD**. Well, Dr. Somers is probably more qualified to speak to that than I am.

I would just simply say that anything that could be done in this area would be helpful. We see long-term care insurance as one of the future saviors in terms of costs around long-term care, but we need to have encouragement not only for individuals to buy these policies to make them more affordable, but also for insurance companies.

Mr. **Schuette**. Let me just take a moment and I will yield back to the Chairman.

Dr. Somers, you want to have a whack at that?

Dr. **Somers**. I appreciate Mr. Ladd suggesting that I might be more qualified, however, I have some constraints as a foundation representative in terms of commenting on things that the Federal Government may or may not want to do.

I would point out though, that in addition to looking at the Federal Government and the States, there are things that the private sector can do. There are things that the private individuals can do. In my testimony, I alluded to both. In light of the constrained resources in the public sector, we ought to continue to examine ways that people can contribute to their own care and that managers of housing projects can contribute to what will make better managed housing projects.

Mr. **Struyk**. Since I am unqualified, can I make a quick comment?

I think there are a couple of things that one could think about. One is the long-term care insurance policies of the kind the Robert Wood Johnson Foundation has been very active in studying. The social health maintenance organization, in effect, a capitated base; you pay a fee, and are assured a range of services.

These plans hold great promise. Most of these, have substantial copayments, and it means it is possible for somebody, even though he is self-insured by participating in one of these programs, to spend down much on the Medicaid model while he is still living at home.

The Federal Government could help in such cases. For a renter insuring himself against long-term care costs, who spends down to a point at which he is eligible for, say, Section 8 existing housing support, then he could be given priority for assistance. In effect, government says: you are not using our resources to take care of your long-term care problems. So we will help you out, if and when you need it by giving you preference for benefits to some nonentitlement programs.

Mr. **Schuette**. I thank you for your comments and yield back my time, Mr. Chairman.

Mr. **Bilbray**. Thank you.

Mr. Ford?

Mr. **Ford**. Mr. Chairman, I am going to yield back at this time. I was still reading over some of the statements from the witnesses.

Mr. **Bilbray**. All right. We will come back to you.

Mr. **Ford**. Thank you.

Mr. **Bilbray**. Mrs. Unsoeld?

Mrs. **Unsoeld**. No questions.

Mr. **Bilbray**. Mr. Pallone?

Mr. **Pallone**. Thank you.

I am really fascinated by the subject today. I see Dr. Somers is from New Jersey. For a number of years, there were efforts in the State legislature to increase funding for congregate housing and to set up new congregate housing sites with State funds similar to the Federal programs.

One of the Federal congregate programs, in fact, is in my district.

The problem was always money. We were constantly trying to come up with the additional funds through whatever sources. We usually looked to the casino funds as the source, and I think the fact that you are suggesting today very emphatically that, you know, a lot more things can be done without additional funds is really great.

I am just a little concerned about what extent to which that is true, though. I am looking at Chairman Roybal's bill and it certainly seems to indicate there are a number of ways to do things to encourage the mixing of services; housing and other services, without spending additional funds.

But ultimately, if we are really going to expand these congregate services and have more buildings similar to the ones that are in the Federal demonstration program are we really talking about significantly more funds being spent or do you think it is really possible to expand these programs in a major way without spending more money?

I guess it is simplistic, but I just wanted an answer, if you could.

Mr. LADD. Mr. Chairman, obviously, the United States spends more money on long-term care services than the—in the United States, we average at any given time 5.2 percent of our population over the age of 65 in nursing homes. No other developed country in the world comes close to that.

If you look to a country that provides long-term care in a similar fashion that we do, you would go to Canada. They do not institutionalize as many people as we do, obviously, and they have a much better way of paying for it. If you look at the percent of the gross national product that is being spent on long-term care in the United States compared to Canada, you see they are about a percent lower than we are, but, yet, they cover everybody. We do not.

So, obviously, we can provide long-term care services to people and not cost as much as we are paying for it today.

Now, the major problem is we just put too many people into nursing homes. If we put them into other congregate settings and a social model, try to make it a partnership so they do for themselves what they can—you know, when we place somebody in a nursing home, we place the nursing home a 100 percent responsible for that person and they provide a 100 percent care.

There are many people in nursing homes who can dress themselves, who can make their own bed, that can help clean up the place and provide even some of their own care. They are not allowed to do so by Federal regulation, State regulation, and the fact that it is a medical model.

Mr. PALLONE. Now, when you talk in those terms, I know that some congregate services include personal care and other health-related services, but others also include meals, where they are actually eating breakfast or lunch on the premises.

Do you ever take that into consideration when you talk about the overall costs.

Mr. LADD. Yes. Yes, I do.

We are developing, as I said, you missed it, assisted living program in Oregon. We expect that we will have half the number of nursing homes in Oregon 5 years from today that we have now, and we will replace those with assisted living facilities which is your own apartment, meals are provided, care is provided. We have had two of those facilities operating for the last 5 years. We have done a demonstration with Medicaid folks in one of them.

What we find is we can provide the same care in those facilities that we are providing in our intermediate care facility nursing homes, a lower level of nursing homes, and we can do so at 80 percent of the cost for both public and private.

Mr. **PALLONE**. Let me ask Dr. Somers. I understood that New Jersey at one time was toying and maybe they have a program now with providing these congregate services not just in public housing facilities, but also in private apartments or even homes in cluster areas where they found groups of senior citizens.

In other words, there might be certain towns where most of the single family homes are clustered in certain areas where it is mostly senior citizens.

Has that been experimented with at all or is that just something that has been proposed?

Dr. **SOMERS**. I believe that in the State of New Jersey, there is a separate congregate housing services program. It is separate from the Federal program, although there may be a Federal site as well. That is one of the reasons why we ended up funding yet another program, the Supportive Services in Senior Housing Program, in New Jersey, because the State has proven to be capable of innovation in these areas.

The difference between the program that we funded and the existing program is that we are trying to get the housing projects themselves to leverage private resources in addition to the public funds. We know that there are limited public funds not only at the Federal level but also at the State level. Those private funds can include reserves from the State housing finance agency and the local projects themselves, and as I mentioned earlier, also individual payments. If people really want something, they are willing to pay for it. I think Mr. Ladd's comments about the inefficiencies of the medical model should be taken to heart.

Several people have asked the question whether or not we can survive on existing resources. I am not suggesting that existing resources are enough in every case, but there are more efficient ways to use existing public resources and to leverage private resources to get a great deal more done in the long-term care area.

Mr. **PALLONE**. Obviously, we have a limited amount of public housing. Support for public housing depends to some extent on whether or not there is availability for more of it. It seems to me that if you could have congregate programs that went beyond the public housing situation, you would probably get more support for expanding some of these services and providing the additional funds. I do not know to what extent that has been tried in New Jersey, but I know that there were some efforts in that regard to do it, in other than public housing sites.

Thank you.

Mr. **BILBRAY**. Ms. Schneider?

Ms. **SCHNEIDER**. Thank you, Mr. Chairman.

My apologies for being late. We had another hearing on a completely unrelated topic, but I did want to ask any of you who are prepared to answer, to what degree you may be addressing a related issue, and that is the national shortage of health care professionals that we seem to be facing.

The number of young people who are graduating from high schools and the failure of many of them to move into the areas of science, math, research and also into the areas of paramedical assistance, I think, is greatly on the decline, and are any of you at all involved in not only being concerned about the facilities and the institutions, but also the people that will work in those?

Mr. Ladd?

Mr. **Ladd**. The problem seems to be more severe on the East Coast than the West Coast, but we do have a problem not only with the health professionals on the West Coast, but also with direct care aides.

We are suffering from low employment, which seems ironic, but it is a fact that all States have a problem with a shortage of help, and part of it is the fact that wages are low in the long-term care area, and I think will remain low. It is very expensive to raise those.

One solution that has started to come about and it seems to be happening primarily in California right now, is the importation from foreign countries some health professionals from those areas.

Ms. **Schneider**. Right. And you are looking upon that as part of the solution? I was hoping I could have some new ideas here, some new initiatives that we could undertake.

Dr. Somers, have you been addressing this?

Dr. **Somers**. This is not exactly the area that I work on at the Foundation, but, clearly, Robert Wood Johnson is very concerned about manpower issues in health. Although I do not think that there is a great concern about the supply of doctors at this point, there has been considerable attention paid to the so-called nursing shortage.

There is clearly a shortage in some areas, and there is an importation from foreign countries in some areas. I think that the most unstudied and perhaps more critical area is that of the shortage of supportive health workers, home care workers, et cetera. The labor pool issue, particularly in States like Massachusetts, Rhode Island, New Jersey and along the East Coast, means that there is a tremendous shortage of low pay workers for low-paying jobs. The Foundation has received a proposal from the University of Massachusetts to try and come up with a demonstration for improving recruitment and retention in that area. We are unlikely to get in to major educational efforts at the high school level or lower, but certainly by combining incentives for further education and training and better job security and better benefits, we might be able to increase that supply.

Ms. **Schneider**. I hope that in the pilot project, perhaps you will address yet another element beyond the skill level, and that is something that Mr. Ladd—a word Mr. Ladd had used a little bit earlier, and that is responsibility.

Granted, I think that there are many people who no longer feel any responsibility for caring for others, and I think that that value ingredient in a discussion would be very valuable as a part of a comprehensive package.

Dr. **Somers**. I would like to comment on that. As you go higher up in the professions, that may become, in some instances, more of a concern. Certainly in the medical education area, there are efforts on the part of people at the Foundation to look at ways to humanize medical education.

Ms. **Schneider**. Well, having Brown Medical School in my State, I am very anxious to do that and do my small part in speeches or whatever. So, if you have information that can help me in that role and share that information with me, I would be greatly appreciative.

Dr. **Somers**. I will do the best I can.

Ms. **Schneider**. Thank you, Mr. Chairman.

Mr. **Bilbray**. Thank you.

Mr. Ford?

Mr. **Ford**. Thank you very much, Mr. Chairman, and panelists. Let me ask you, is there any legislation that is before the Congress today, and I missed the testimony from the members of this panel, is there legislation before this Congress without any revenue impact that would cause any problems for the huge deficits that we are running here in the Congress?

I ask that because the Secretary of HHS testified before the Ways and Means Committee about 3 weeks ago on budget reconciliation. There he proposed in the President's budget a flexible freeze in the area of health and human services. Many of the programs we are talking about fall within categories that would be under the flexible freeze of the administration.

My question concerning any legislation or bills before the Congress was so that we could look at and possibly respond to some of the problems that the frail elderly are confronted with in this country, knowing that we are currently spending approximately $19 billion on nursing homes, as well as nursing care.

Are there any areas which we can consider in this Congress and respond with legislation.

Mr. **Bilbray**. I think when you answer that question, too, it may be in reference to Chairman Roybal's bill, which is reportedly revenue neutral to it, and does that address the problems Mr. Ford has brought up?

Mr. **Ladd**. Well, I think Chairman Roybal's bill, I have not had a chance to really go over it, I just got it a couple of days ago, but I did read through it, and I think that goes a long way towards resolving some of the problems.

In my mind, it does more than resolving a problem. It kind of sets the Federal Government on a different path. Going down that path is going to have positive results in the future.

Our congressman, who is a member of the full Committee is Congressman Wyden, who has introduced 1453, which is to allow Medicaid services to be an optional part of Medicaid program, would go a long way in that direction. That does have a few costs.

Other than that, we have our State legislature session right now, and as the Aging Head of the State of Oregon, I have been concentrating on State legislation and have not pursued much on the Federal side this year.

Mr. **Ford**. Are there any others?

Mr. **Katz**. Well, I think the issue that we should bear in mind, which has been mentioned, by several of us, is the fact that the alternative to developing a more effective congregate housing program is the construction of more nursing homes or similar kinds of settings, and the evidence has shown clearly that nursing homes are much more expensive both for Federal outlays and for State outlays.

The situation in Illinois, is a bit troublesome to me because that is my home State and we are the only State in the Union with a population of a million or more elderly people that has not got a State congregate housing program, even though data has shown that such a program would result in a substantial cost saving to that State.

One of the reasons why it has been difficult to get a program going is that the savings for such a program will come out of one departmental budget and any new revenues that will flow will go into another department.

I suspect the same thing could be true with the Federal level, that, if you are able to show that there may be a saving in one area, there is going to be expenditures elsewhere, and the agency that is absorbing the cuts is the one that is going to have a tough time in swallowing that. There is reason to suggest that the typical separation of housing development from social service support efforts which, from the point of view of actual delivery of quality housing and services has not served us very well. As we attempt to correct some of the problems we can anticipate battles between those who are going to take the cuts and those who are going to get the additional revenues.

But, clearly, I think the evidence is there that congregate housing is and has been shown to be a cost effective and cost saving program. We are past the point of saying that we need more demonstration projects. I am encouraged by the proposed legislation that your chairman has produced and similar recommendations in the Cranston-D'Amato bill which also proposes developing more congregate programs.

It should be a Federal responsibility to provide funds, but the States also have to share some of the costs. I want to make it clear that many of the groups I have dealt with are public housing agencies and their residents. These people are not in the financial situation to be able to afford costs of private congregate housing. Public expenditures are required and failure to enact legislation and failure to fund these kinds of programs will not stop the process of aging-in-place, and will not stop the changes in our population as we are an aging society. These costs will be borne by somebody at some time, and we are saying that your directions are correct, and that we should start moving on this. It may require some dollars now, but in the long run substantial savings will be realized by those expenditures.

Mr. **Ford**. Dr. Katz, what do we envision in the future? You spoke about the growing demand for additional nursing homes and congregate care. We are presently under the Medicaid program spending billions of dollars in nursing homes.

Should we create new programs as we approach the 21st Century foreseeing that the nursing home elderly population will double? Or do we continue the programs already in existence or do we set up or create other new programs to address the congregate nursing home care issue?

Mr. Katz. My view on this is that we never have solved the problem. It is always going to change its shape somewhat. There are a lot of good programs in existence today and those, I think, should be continued. A lot of good ideas have been put forward and those should be tried.

Yes, I think as we look forward to the future of our aging society, new programs will be required. The shape of those will emerge in part from the kind of research that is underway, the findings from the Robert Wood Johnson studies, and others are going to help us in that direction.

I think that, clearly, one of the things that has been shown in the last few years is that the coordination of service delivery rather than individual delivery to individual clients is something that is going to be more an issue before us and may suggest certain new programs.

I do not think we can ever expect to have a "solution." I do not think we are ever going to be satisfied because as soon as we solve one set of problems or resolve them, others will emerge. The demographics tell us from the population that has already been born, that we are an aging society, and we are going to need more kinds of supportive services for that population.

People are living longer. They are living healthier. There is a situation of the old old, and as I mentioned in my testimony, the people that have either started congregate housing programs or converted to congregate housing settings have discovered that the aging process does not stop. The people who are now able to remain in congregate settings because meal services and housekeeping and transportation and other related services are available will require additional services over time, and these services are going to require expenditures at somebody's level, whether it is private pay or it is some form of copayment.

Mr. Ford. Many of us in the Congress will be very interested to know what certain academic institutions are doing, and, what information you will give the Congress and the Aging Committee, as well as other Members of this body, as to how we should address these issues in the coming years. We realize this will be a growing problem in this country, and many of us will look to many of the academic institutions for guidance.

Mr. Struyk. Just a quick comment. My institution has prepared a report under congressional mandate, Section 163 of the 1987 Housing and Community Development Act, on options that has been delivered to HUD and has not yet, however, been delivered to the Congress.

The theme of that report is that we have got something on the order of 5 to 10 years to be in an aggressive period of experimentation, demonstration, and evaluation to get ready for the very large increases in the number of elderly that are going to be with us shortly thereafter. That report has several different models with rather different incentives from those that are currently in place which we think ought to be experimented with. But at the same time, following what Dr. Katz says, we think you ought to keep the congregate housing services program and adjust it as well to use to measure the extent of improvement being achieved through some of these new options.

Mr. **Bilbray**. One quick comment from Dr. Somers and then I think we better move on.

Dr. **Somers**. Though I cannot comment on specific legislation, I laud any attempts to increase the connection, conceptual and otherwise, between housing and services. I would also indicate on the Medicaid issue, and I do not know the specific legislation here, that there are ways for the Federal Government, State governments and the private sector to work together on long-term care insurance and the development of new products that would be, I believe, budget neutral.

Mr. **Bilbray**. All right. Mr. Kennedy.

Mr. **Kennedy**. Thank you, Mr. Chairman.

I apologize for not being here to hear your testimony. I tried to look through some of it, and it is an issue that means a great deal to the people up in my district.

Obviously, with the circumstances with the 85 year old individuals in our country being the fastest growing portion of the population and knowing that for every person living in a nursing home, there are at least two in the same community that have the same types of problems that those in the nursing homes have, obviously the issue of how we are going to care for people in their own homes becomes really, I think, one of the critical issues.

In the district that I represent, we have had tremendous rises in the value of real estate. An elderly individual who lives next door to me has a home which is probably worth about $300,000, which 7-8 years ago, that house would have been worth around $40,000.

So, the value of homes has risen dramatically, and, yet, the number of congregate elderly apartments in the 8th District of Massachusetts can probably be counted as a few hundreds. Yet, it would seem to me that if you assume—let us assume that Helen's house is worth $250,000, just to pick a number, that she could buy a congregate housing apartment for a $110-115,000, and then she would obviously use the difference between the 250 and the 110 or 115 in a bank account and have a reasonable salary rather than living on SSI which supports her—this is my next door neighbor. So, I happen to know she gets about $447 a month. She—her husband died and she has very, very little income. It is a very sad situation, but, nevertheless, it would seem to me that if somebody should come up with initiatives to get the private sector to take care of a lot of these problems, and, yet, somehow or another, we are not able to do it.

And I wonder if you could comment on what you think some of the problems that are preventing the private sector from taking over. We insist on always talking about how we can spend the government's money, but it does seem to me that in some of these cases, there is still a lot the private sector could be doing, ought to be doing, and for some particular reasons is prevented from jumping into.

You nodded a couple of times, Doc. Maybe you could take a crack at it.

Dr. **Somers**. That is a good question. What immediately comes to mind is the notion of home equity conversion, which may or may not have been discussed here.

I think the major impediment to home equity conversion is that people like your neighbor are unwilling to give up their major asset, which is that house. That is a real comfort to many people. Clearly, in purely rational terms, with $300,000 or $250,000, you could purchase a great deal of care. Home equity conversion may be an idea whose time has not yet come, but it is coming. When people are more comfortable with the notion of giving up that asset in order to come up with a reasonable stream of income to pay for services and a comfortable quality of life into the future and when banks get better at dealing with the notion of reverse annuity mortgages, et cetera, there will probably be more activity in this area. The Federal Government, as I understand it, has made some efforts to facilitate that activity through FHA mortgage insurance for reverse annuity mortgages.

Mr. **Kennedy**. Do you have any comment on that?

Mr. **Katz**. Yes, I could comment in a couple of directions on what you are suggesting.

The area that you are talking about is an area that I spent 3 years studying with another foundation grant. It is a significant one. Time does not permit today to describe the full report of that study.

However, one of the conclusions was that what was missing was a program which we do not have at the Federal level, which I have called, for lack of a better term, the "last time home buyer program." We have given incentives for first time home buyers. There may be some reasons to suggest that people who are making a move as you are suggesting your neighbor might make would need some incentive to make that move.

Primarily, the situation is that the majority of our population in this country, including the elderly do not live in institutions and chooses not to, and by this, I mean any kind of assisted housing. We are talking only about 5 percent of those persons over 65 in this country who currently live in some form of assisted housing or housing which is called purpose-built for the elderly.

So, 95 percent of our elderly population are living in their own homes and choose to do so. However, for many of them their housing is not desirable. The house is often not appropriate for the elderly occupants, but it is their home, and to suggest otherwise is a mistake.

Unfortunately, again, maybe the word unfortunately is wrong here, but let us say that the move that most people make when they do move is a result of trauma in their life. Death of a spouse, an onset of illness, a financial problem or some other situation. The move itself is traumatic.

So, when we find that people are forced to leave their home, we say it is adding trauma on top of trauma. If we could find some way of encouraging the kind of person you are describing to make that move voluntarily, perhaps not when they are 85 but when they are 75 or 80, to a setting which is purpose-built for their needs, that would be desirable. So, certain kinds of incentives might be desirable there.

I want to also comment that we should not lose sight of the fact that while the person next to you has a home valued at that high figure, which is certainly true in many parts of the country, it is not true in parts of the country. There is a substantial number of elderly people who are poor, who are living in homes which are in need of repair and they cannot afford to make those repairs. These people are the ones who we must not neglect as well as those who have the resources.

Mr. KENNEDY. I obviously could not agree with you more, and I did not mean to suggest that this was in any way going to solve the total problem.

I do think that we are kind of in a Catch-22 in the sense that because there is a perception that the elderly are not—or the seniors are not willing to participate in these kinds of programs, the programs are not offered and, therefore, it gets very, very difficult for an individual like Helen to actually find an alternative.

You know, in the City of Boston, we probably have just a slightly, if not in some very large neighborhoods, less population today than we did a hundred years ago, and, yet, we have a tremendous housing crisis today that we did not have a hundred years ago.

One of the reasons is a woman like Helen is living in a house that has five or six bedrooms, she lives all by herself, is that her children have moved off. It is a terrible use of that particular piece of property.

Now, in terms of the basic society, not for Helen, I do think that if we had programs available where active marketing was done, where people were told exactly what kinds of alternatives, not that Helen would have to move into a different neighborhood across town where she does not know any of the people, but if we had a congregate housing program right in my neighborhood. I think commercial development could make that work, if, for instance, if church groups and other organizations that senior citizens are normally a part of, could feel that they could take part and offer the supportive services.

Now, it is not going to solve all the problems in other areas of the country. I am not pretending it does, but it does seem to me we have to take some of these problems in small bites and see what progress can be made, and I just have a sense that there is a tremendous potential out there.

It is not in all parts of the country, but there is tremendous potential, but it is just going completely wasted on the sidelines.

Mr. KATZ. If I may comment just one bit further on that, you might look at what the British experienced, the so-called "Abbyfield Model". The Abbyfield Society of Britain has taken some of the older houses, converted them into small congregate settings in typical neighborhoods and it is working in a way that is fairly successful.

One of the things that we have to look at here, however, is the major issue of zoning. So, here again, Federal programs are appropriate, but the local zoning has to be flexible enough to allow a number of elderly to live together in a small congregate setting.

Mr. KENNEDY. But these are issues that we struggle with all the time.

Dr. Struyk, would you like to respond?

Mr. SOMERS. Yes. I would like to pursue something that Mr. Kennedy is putting forth, and that is the idea of marketing. Corollary to that is the degree to which most of our programs are designed by professionals, in the field of aging or health care who are setting eligibility criteria and reimbursement streams that are constrained because we just do not have unlimited resources. This factor is hampering our ability to develop and design products that elderly people really want and need to remain independent.

In both of our programs that I discussed today, the Supportive Services Program and the Supportive Services in Senior Housing Program, the first thing we are asking them to do is market research. Ask older people what they want themselves in order to remain independent, to have a better life, to unload $300,000 houses, whatever it is. One of the programs that is likely to be developed over time in some places is financial counseling of the kind that would enable your neighbor to do better.

Mr. KENNEDY. Thank you very much, Doctor.

Mr. BILBRAY. Mrs. Bentley?

Mrs. BENTLEY. Thank you, Mr. Chairman.

Following along the lines of Mr. Kennedy's questions and your answers, did the—when the tax shelters were removed in the 1986 Tax Reform Act, has that had an adverse effect on the private sector building of low income houses for the elderly?

Mr. BILBRAY. Anybody want to answer that or no one knows the answer to that? Mrs. Bentley, next question.

Mrs. BENTLEY. Okay. I think it has. Okay.

What percentage of the people who are in nursing homes are citizens who really do not want to be there and should not be there, but the only reason that they are there is that they cannot maybe dress themselves in the morning or they cannot feed themselves?

Do you have any idea on that figure?

Mr. LADD. Well, I think that percentage varies across the country. The number—the percentage—the way we measure States against each other is we look at the the number of people per 1,000 over age 65 that are in nursing homes with the average around the country being 52.

That varies all the way from about 24–25 in Florida up to a 106–107 in the State of Minnesota. It is just variable all over the country.

Mrs. BENTLEY. Would you repeat those figures, please?

Mr. LADD. About 24 or 25 in the State of Florida is the lowest up to a 106 or 107 in the State of Minnesota.

The Midwest States seem to have a higher percentage than either the East Coast or the West Coast.

I have been in a number of those States. I did a survey in the State of Oklahoma last year for the National Governors Association at the request of Governor Bellman. Three of us went down there and looked at Oklahoma's nursing homes, and they have 76 per thousand, and in that State, I was able to identify a number of people who, in my professional opinion, need not have been in nursing homes, but they did not have the large number of alternatives available for the people to go to.

That varies. I have also looked at people in the State of Florida. They, even with the low numbers, still have a number of people in my professional opinion who are in nursing facilities that need not be there. They could be in alternatives.

So, the number is variable. It depends from State to State. In my own State of Oregon, we are estimating that 50 percent of those folks in nursing homes could benefit from alternative placement and we expect within 5 years that we will have half as many nursing homes as we have today because we will have provided that alternative placement that fills that need.

Mrs. **Bentley**. When you are classifying these in nursing homes per se, are you including in there some of the communities, the senior communities, where they have apartments for those people who are able to take care of themselves in the community, but later on there is a nursing home in the facility that they can move into when they need medical care, et cetera?

Now, are you including the people in the individual units in that figure?

Mr. **Ladd**. You are speaking of community care retirement communities?

Mrs. **Bentley**. Yes.

Mr. **Ladd**. No, not really. Those—in those areas, we see a much more rational use of that resource. In most of those types of projects, where they really attempt to keep people as long as possible in their own apartment because that is part of the complex, and really not move them to the nursing facility part of that complex until that becomes absolutely necessary.

So, you would say that those facilities are—really have been a success wherever they have been built?

Mr. **Ladd**. Generally, yes.

Mrs. **Bentley**. Okay. That is all the questions I have.

Mr. **Bilbray**. Okay. Mr. Vento?

Mr. **Vento**. Well, thank you, Mr. Chairman.

I was busy in the Interior Committee passing out your Nevada Landfill Act.

Mr. **Bilbray**. Yes, I appreciate that. You were doing service to your country and my State.

Mr. **Vento**. We attached a little amendment to it to help the coastal areas, too, that Helen will be happy to hear about, I think.

Mr. **Bilbray**. Took a simple land exchange and made an environmental bill. I appreciate that.

Mr. **Vento**. Anyway, I am pleased to note that the Chairman has called this hearing because this is an area that certainly on the Housing Subcommittee that I have had an interest in along with Representative Kennedy and Congressman Oakar and others, and I know that there has been some study, on-going study based on the 1987 law that Mr. Struyk has been contracted to do for HUD, and I guess we are going to hear from Secretary Kemp in a few weeks on that topic.

But I think that it is important. I know I have not read all the witnesses' testimony, but there seems to be what I refer to as a convergence between housing or shelter issues and various social service type of issues, and we see it in each of our communities. In my own community of St. Paul, Minnesota, they have had a lot of programs. They had been one of the pilot areas for the congregate services program, which you have been studying, Mr. Struyk, and they have received an award-winning program, called "The Block Nurse Program", where they actually provide services in their own communities on that basis.

And, so, I do not know, I think that we can all agree—now we have to go vote, but we can all agree that there needs to be services, but I think what we are concerned about is sort of to start with the congregate housing services program through—either through 202 or other types of public or assisted housing programs in that format, and, so, I am most interested in some of the comments, I suppose, in depth, which I know are going to have to wait for the Secretary to come up to ask, but the—I think that what is pointed out here in the background paper which we have, and I do not always remember these numbers, that we only have 2,000 elderly across the Nation that are participating in the congregate housing services program.

Is that correct, Mr. Struyk?

Mr. STRUYK. Yes.

Mr. VENTO. So, I mean, that is the model, and would you say that that is an accurate, an adequate research base to get the type of readings that you have done here? I guess it would be better to have more of it, but how do you feel about that as being sort of the basis to extrapolate as to what the policy impacts are?

Mr. STRUYK. I think it is a good short-term basis, but in looking over the experience with several State congregate programs last summer as well as the CHSP and the Farmers Home demonstration, we think that in the next 5 to 10 years we ought to experiment fairly heavily with some alternative models. CHSP especially as it has been refined over the last few years, is doing a better job at defining frailty and changing the mix of services, and has become a much more effective program.

There are still some incentives in the ways that congregate programs work that could be reoriented to make them somewhat more effective, and we would like to demonstrate such changes.

Mr. VENTO. One of the concerns I always have when we start writing these is, you know, we think we discovered the wheel and only found out that somebody else had been doing some other things.

Is there a lot of overlap with regard to the—some of these programs, the State CHSP or the—are there a lot of overlap with other programs or not?

Mr. STRUYK. There are nine States that have congregate programs that are very similar to CHSP, and the States, and I think Mr. Ladd can comment on this, have a number of other options where they are combining housing and support services in fairly interesting ways that offer some other models.

Mr. VENTO. Is it your judgment that they all have—you pointed out in your testimony some screening problems, I think. Did they all have screening problems?

Mr. STRUYK. No. Earlier today, I suggested that Oregon just is exempt in terms of the care with which it does its screen; but some of the States have problems. These are very localized, at the individual project level.

Mr. VENTO. The screening problems are nothing new to any type of nursing care or health care model, are they? I mean, would you say this is considerably excessive here compared to other types—the health care model in terms of screening?

Mr. STRUYK. You are screening for rather different phenomenon, and I would say that in some cases, certainly for one or another of the State programs, the screening looks fairly loose. The expansion proposed in the legislation of services to, say, public housing is worrisome. The report done by Citizens Housing and Planning in Boston for the Council of Large Public Housing Authority, says that only 8 percent of their managers have real assessments on elderly servicing needs.

Mr. VENTO. So, it is a matter of trying to get the administrators up to speed in terms of training, in terms of identifying and doing proper screening.

You know, I guess I just think that if there are some excesses in here, that they want to be careful about, but, I mean, I am not so concerned because I think the excesses here are a lot less costly than those that might occur, for instance, down the road with regard to—the problem I have, I know—maybe I misunderstood what you suggested here. I just read it quickly. But it suggested that you thought that the waiting lists were all right in this instance with regard to frail elderly. You thought there were waiting lists for these services? Did I misunderstand?

Mr. STRUYK. Yes, you did misunderstand me. What I was saying was that the proposal in the legislation is to have a centralized waiting list in a given area, and I think that for elderly, especially designed elderly housing projects, I think that is good because it would expand the range of opportunity any given elderly person had as opposed to applying an individual project and getting in a single que. You would get in all the ques at one time.

Mr. VENTO.Well, my concern is this, I mean, whether I misunderstood it or understood it, but the concern is that mostly these instances with the frail elderly sometimes it is not sort of a gradualism. It is sort of dramatic. The events that happen are rather dramatic, and when there is not a—if it is a less restrictive environment, less costly environment, you could place them in that environment. Normally, you do not anticipate that 6 months from now, I am going to have some sort of a disability.

Mr. STRUYK. But the waiting—if we had excess capacity or marginal excess capacity, that would be terrific, but, in fact, there are waiting lists for all these projects. So the question is how do you organize the process not whether it exists; their existence is a fact of life that we will not solve without a massive expansion in the number of slots.

Mr. VENTO. Well, Mr. Chairman, my time has obviously expired. We have to go vote. But I appreciate the work done by the members of this panel, and I will look over this recommendation. The recommendation from Mr. Roybal with regards to the changes in housing law which is being considered this year by our subcommittee.

Mr. BILBRAY. Thank you. Mrs. Morella?

Mrs. Morella. Thank you.

I know that there is not very much time, and I, while others were busy at other meetings, too, I was at Metro Funding Reauthorization which is important to everybody in the Washington area and the country. But I just wondered about the role of the private sector. Do you see—we talked about federally funded subsidized housing for frail elderly. Do you see that with the additional expense and the need to expand, the private sector assuming a role?

Mr. Struyk. You know, Steve Somers has addressed this earlier, and I will give—let him handle it. I think he made a very good statement before.

Mrs. Morella. I am sorry if you have already mentioned it, Dr. Somers. Maybe you could just say yes, no, and I will read what you said.

Dr. Somers. I will say yes in the interest of your having to go vote. Indeed, the private sector can play more of a role.

Mrs. Morella. Are you doing something about it?

Dr. Somers. We have a demonstration program for providing services in senior housing projects across the country, which is described in my testimony.

Mrs. Morella. Very good. And, finally, with the high cost for this care; I guess it has been estimated that $20,000 per year is needed for frail elderly in a nursing home. What would be the comparable cost for somebody who did not need a nursing home but had the assistance of one or two people? What do they call them? ADLs?

Dr. Somers. We could all come up with different numbers, depending on the kinds of services available and on how you calculate room and board cost, but I think it can be done for $5,000 or $6,000 as opposed to $20,000.

Mrs. Morella. Really? Again, that's a very, very interesting point that we may want to continue to explore. Thank you very much.

Mr. Bilbray. Gentlemen, the committee has additional questions that we would like to submit to you, but what we would like to do, because we are going to have to shut down now, and I doubt if we will get anybody back after this vote because it is going to be a series of amendments, we would like to submit them to you in writing and ask you to respond to the committee. There are some important questions because this is important legislation.

We thank you for your patience. It has been an interesting morning and certainly had a lot of participation from the committee, showing the vast interest they have in this area. The only question I have is, Dr. Somers, how can I get one of those foundation grants so I can start one of these projects in the first district of Nevada?

Dr. Somers. Start a 501(C)(3).

Mr. Bilbray. Okay. Thank you.

The hearing is adjourned.

[Whereupon, at 11:30 a.m., the hearing was adjourned.]

HOUSING FOR THE FRAIL ELDERLY

WEDNESDAY, JULY 26, 1989

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC

The committee met, pursuant to notice, at 9:28 a.m., in room 311, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal, Oakar, Wyden, Borski, Clarke, Kennedy, Jontz, Pallone, Unsoeld, Rinaldo, Snowe, Schneider, Bentley, Lightfoot, Schuette, and Morella.

Staff present: Manuel Miranda, Staff Director; Mary Hanlon, Professional Staff; Valerie Batza, Executive Assistant; and Diana Jones, Staff Assistant.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. The hearing will come to order. On May 4 of this year, the Select Committee on Aging held a first of two hearings to examine the needs of the frail elderly living in Federal subsidized housing. The first hearing consisted of a panel of four experts, all experts in the field, who have developed congregate service housing programs and who have evaluated existing programs. That first hearing reviewed the most recent available data on the needs of the frail elderly and the various resources to the diverse housing options.

This, ladies and gentlemen, is the second hearing on this subject matter. We are fortunate today to have the Secretary of HUD, who will present the administration's viewpoint with regard to this subject matter. I would like to welcome the Secretary to the committee this morning. I had the pleasure and the honor of serving with him on another committee when he was a Member of the House of Representatives. He and I were members of the Committee on Appropriations, and, believe it or not, we seem to have been on the same side in many instances, particularly when it came to those problems that affected the elderly and the poor of our community and of this country.

I was very delighted, Mr. Secretary, when I heard that you would be appointed as Secretary of HUD.

Mr. KEMP. Thank you, Mr. Chairman.

The CHAIRMAN. For I know your background, I know how you feel about these things, and I know that you will do everything you possibly can to see to it that the elderly of this Nation are not forgotten.

But before we start, Mr. Secretary, as you know, we have a custom that we must follow, and that is that every member of the committee is given an opportunity—that is, in 1 minute—to make an opening statement. The chair now will recognize Mr. Rinaldo, the ranking minority member.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. **Rinaldo**. Thank you very much, Mr. Chairman. I certainly want to second what you said about Secretary Kemp, and I'd like to join you in extending a warm welcome to our former colleague and my good friend, who is doing such an excellent job as Secretary of HUD. I know his schedule is extremely busy, and I'm sure we all appreciate the opportunity to discuss elderly housing with him this morning.

This is the second part of our hearings on housing for the frail elderly. I won't go into great detail in my opening statement. I think we should certainly reserve everyone's valuable time for a full exploration of the administration's views on the pressing problems we face in meeting the housing and support service needs of the frail elderly. I think it is important, however, to sketch out several key points to give us a perspective on the issue.

I think we have to bear in mind that America is aging rapidly. If present trends persist, we will witness a 50 percent increase in the United States nursing home population between 1985 and the year 2000. This figure is made even more staggering when paired with the fact that the average annual cost of nursing home care easily exceeds $25,000; in fact, it is around $30,000 in my particular congressional district. In 1986, $38 billion was spent on nursing home care and 40 percent of that through Federal, State, and local programs. Medicaid alone paid 41 percent of the total national nursing home bill. I feel strongly that there are less expensive ways to provide care for the frail elderly.

More important than these cold numbers, however, is the imperative of maintaining a high quality of life for older Americans. If at all possible, most seniors prefer to stay out of nursing homes. Many are forced into nursing homes prematurely or unnecessarily because they cannot perform all of their daily tasks alone.

Mr. Chairman, I strongly support the goals of this hearing. Housing for the frail elderly must become a priority before it becomes a catastrophe. These people are among the most vulnerable in our society, and the time is right to begin meeting their basic needs in a more effective fashion.

I look forward to the administration's views on this difficult and complex issue and yield back the balance of my time.

[The prepared statement of Representative Rinaldo follows:]

Matthew J. Rinaldo

OPENING STATEMENT OF
CONGRESSMAN MATTHEW J. RINALDO
RANKING MINORITY MEMBER

HEARING OF THE HOUSE SELECT COMMITTEE ON AGING
"HOUSING FOR THE FRAIL ELDERLY"

JULY 26, 1989

MR. CHAIRMAN, I'D LIKE TO THANK YOU FOR CONVENING THIS HEARING AND JOIN YOU IN EXTENDING A WARM WELCOME TO OUR FORMER COLLEAGUE, HUD SECRETARY JACK KEMP. I KNOW HIS SCHEDULE IS EXTREMELY BUSY AND I'M SURE WE ALL APPRECIATE THE OPPORTUNITY TO DISCUSS ELDERLY HOUSING ISSUES WITH HIM THIS MORNING.

THIS BEING THE SECOND PART OF OUR HEARINGS ON HOUSING FOR THE FRAIL ELDERLY, I WILL NOT GO INTO GREAT DETAIL IN MY OPENING STATEMENT. I THINK WE SHOULD RESERVE EVERYONE'S VALUABLE TIME FOR A FULL EXPLORATION OF THE ADMINISTRATION'S VIEWS ON THE PRESSING PROBLEMS WE FACE IN MEETING THE HOUSING AND SUPPORT SERVICE NEEDS OF THE FRAIL ELDERLY. I WILL, HOWEVER, SKETCH OUT SEVERAL KEY POINTS TO HELP GIVE US A PERSPECTIVE ON THIS ISSUE.

AMERICA IS AGING RAPIDLY. IF PRESENT TRENDS PERSIST, WE WILL WITNESS A 50% INCREASE IN THE U.S. NURSING HOME POPULATION BETWEEN 1985 AND THE YEAR 2000. THIS FIGURE IS MADE EVEN MORE STAGGERING WHEN PAIRED WITH THE FACT THAT THE AVERAGE ANNUAL COST OF NURSING HOME CARE EASILY EXCEEDS $25,000. IN 1986, 38 BILLION DOLLARS WAS SPENT ON NURSING HOME CARE, 47 PERCENT OF THAT THROUGH FEDERAL, STATE AND LOCAL PROGRAMS. MEDICAID ALONE PAID 41 PERCENT OF THE TOTAL NATIONAL NURSING HOME BILL. I FEEL STRONGLY THAT THERE ARE LESS EXPENSIVE WAYS TO PROVIDE CARE FOR THE FRAIL ELDERLY.

MORE IMPORTANT THAN THESE COLD NUMBERS, HOWEVER, IS THE IMPERATIVE OF MAINTAINING A HIGH QUALITY OF LIFE FOR OLDER AMERICANS. IF AT ALL POSSIBLE, MOST SENIORS PREFER TO STAY OUT OF NURSING HOMES. MANY ARE FORCED INTO NURSING HOMES PREMATURELY OR UNNECESSARILY BECAUSE THEY CANNOT PERFORM ALL OF THEIR DAILY FUNCTIONS ALONE. OUR TASK, IN MY VIEW, IS TO DEVISE OPTIONS OTHER THAN, ON THE ONE HAND, TOTALLY INDEPENDENT

LIVING, AND ON THE OTHER, INSTITUTIONALIZATION IN A NURSING HOME SETTING.

EXPERTS IN THE FIELD MAINTAIN THAT AT LEAST ONE-QUARTER OF OLDER AMERICANS IN NURSING HOMES DO NOT NEED THAT LEVEL OF CARE. MANY ARE IN NURSING HOMES SIMPLY BECAUSE THE ALTERNATIVES DO NOT EXIST FOR THEM TO LIVE INDEPENDENT LIVES WITH MINIMAL ASSISTANCE. THE EFFECTIVE LINKING OF ELDERLY HOUSING WITH ASSISTANCE IN DAILY ACTIVITIES LIKE SHOPPING AND COOKING IS ABSOLUTELY ESSENTIAL IF WE ARE TO PREVENT THIS UNNECESSARY PHENOMENON.

I STRONGLY SUPPORT THE GOALS OF THIS HEARING. HOUSING FOR THE FRAIL ELDERLY MUST BECOME A PRIORITY BEFORE IT BECOMES A CATASTROPHE. THESE PEOPLE ARE AMONG THE MOST VULNERABLE IN OUR SOCIETY, AND THE TIME IS RIGHT TO BEGIN MEETING THEIR BASIC NEEDS IN A MORE EFFECTIVE FASHION. I LOOK FORWARD TO HEARING THE VIEWS OF THE ADMINISTRATION ON THIS DIFFICULT AND COMPLEX ISSUE. I THANK THE CHAIR.

The **Chairman**. Thank you. The chair now recognizes Ms. Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. **Oakar**. Thank you, Mr. Chairman, and once again I want to welcome you in my Aging Committee, Mr. Secretary; we are delighted to have you here. I think you are the first Secretary of HUD, since I have been here, that appeared before the Aging Committee; I could be wrong; but I think that is really significant.

The fact is, as everyone knows, the fastest growing population are people over 85, and we have 600,000 elderly, as an example, living in public housing, 202, subsidized housing projects. They have been living there since age 65. Many of them stay there until they die, and the fact is, as they get older, they get more frail, and we do not provide congregate services for them.

I serve on the Bipartisan Pepper Commission on Comprehensive Health. We are supposed to report back to Congress in the next 2 months. I think the problem that we have had—and I know, Mr. Secretary, I have told you this privately—is that we cannot divorce and isolate housing from services and health care and so on, and so I have introduced some legislation in the past that would provide day care programs for the elderly, provide homemaker services, provide sort of visiting nurse type activities so that we can keep people out of institutions who want to stay in their home.

I have often said that you ought to get the waivers you need to put together a comprehensive package that includes housing and comprehensive services under the auspices of HUD for our elderly, some model pilot projects. I think it would be terrific, I know you can do it, and I know you are ready to meet these challenges, and I look forward to working with you.

Mr. **Kemp**. Thank you.

The **Chairman**. Thank you, Ms. Oakar. The chair now recognizes Ms. Schneider.

STATEMENT OF REPRESENTATIVE CLAUDINE SCHNEIDER

Ms. **Schneider**. Thank you, Mr. Chairman. Considering we have so many Members here today and in the interests of time, I would like to ask that my comments be submitted to the record in their entirety, if I may.

The **Chairman**. Without objection, that will be the order.

[The prepared statement of Representative Schneider follows:]

PREPARED STATEMENT OF REPRESENTATIVE CLAUDINE SCHNEIDER

Mr. Chairman, today I would like to bring to your attention a sometimes forgotten group of people who may not be able to speak for themselves, so we must speak for them. I am talking about the frail elderly in our communities. Today there are 1.5 million elderly living in nursing homes in this country, and for every one of them it is estimated there are about three more being cared for at home. We face even greater challenges in the future as demographics show the fastest growing age group is those who are age 85 and older, by the year 2030, three percent of our population may be in this category. As Americans we should view these facts with joy, after all we are living longer. It is so very critical that we recognize the need we have today to care for our frail elderly as well as thinking about the foundations we lay for the future.

Presently, there is no federal program which is designed to support the long term care needs of the elderly, long term care providers, or nursing homes. Eighty-five percent of the long term care being provided in this country today is administered by family members. Clearly, I do not believe that families have abandoned their elders, but I do believe that we have abandoned our responsibility to provide support and assistance to the family. When we think about the frail elderly person, we may be only seeing half of the picture- the individual who is in need of assistance. We also need to broaden our view and see the family network. Families also need support, respite and assistance in order to remain connected and active in the caregiving which can be so very life enhancing for the older person.

Naturally, when we acknowledge that there should be a "continuum of care" available for individual needs, we realize that we need to fill in the continuum of services to meet the needs. Presently, there seem to be very few options between independence and nursing home care. Both are at the far ends of this continuum. In my home State of Rhode Island we have a few shelter care programs, as well as "assisted living " programs. I am very encouraged to see these creative approaches to care being initiated. We need more creative initiatives by the private and public sector. Offering a range of services only makes good common sense and good fiscal sense. We often hear about the "institutional bias" toward nursing home care and we need to shift that focus to a broader range of options.

Nursing home care is a critical area of need. For the very sickest elderly, or those who need 24 hour a day contact there is no substitute. Again our demographics show that by the year 2040, 4.4million people will be nursing home residents. As you can imagine the need for more nursing home beds is critical. Even in my home state I know of cases of people having to wait in hospitals until a bed becomes available in a nursing home. This problem will only become worse if we refuse to address this problem now while it is still "manageable".

For many of us, there will be two periods of time in our lives where the need for assistance for the frail elderly will become very personal. First as our own parents and relatives age we will be confronted with the realities of bringing care to those whom we love. We also must also recognize the very personal nature of our mission as legislators, as leaders. It is our personal responsibility to accept our own human condition. If we are fortunate enough to live to a "ripe old age" we will find ourselves walking down the very path that we have laid. The time we have now is vital for setting the priorities that we will have to live with in the future.

Ms. **Schneider**. And let me just welcome you, Mr. Secretary, and congratulate you on the stellar job that you are doing. Granted, housing for the frail elderly is a top priority for Rhode Island, as you know, having visited my fine State. But we are number two in the Nation in terms of elderly population, and, as Ms. Oakar points out, those numbers are increasing. My philosophy has always been one of prevention and acting prior to crisis management. So I commend you for the work that you are doing and look forward to supporting you in your creative initiatives.

Mr. **Kemp**. Thank you.

Ms. **Schneider**. Thank you, Mr. Chairman.

The **Chairman**. Thank you, Ms. Schneider. The chair now recognizes Mr. Wyden.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. **Wyden**. Thank you very much, Mr. Chairman. I, too, will be brief. We are very pleased to have our former colleague here. It was great to work with him in the House, and it is going to be a pleasure in this capacity as well.

Mr. Secretary, there are two points that I am particularly concerned about. One is, I'm interested in knowing whether HUD has a formal strategy for trying to keep this problem of unnecessary institutionalization of older people from getting worse. We know that in this country every single night probably 20 percent of the older people who are in institutions wouldn't be there if there were adequate alternatives. and what I am interested in knowing is whether HUD has a formal strategy in place for dealing with it, because I think it is one thing we can agree on a bipartisan basis would help stretch the resources.

The other point that I'd like to know, Mr. Secretary, is, what effect has it been on your programs, the problems of your predecessor, as it relates to the elderly? I know one of my colleagues earlier asked you about the total cost of the problems that you have inherited. You indicated it was about $2 billion. I would be interested in knowing today, of that $2 billion, how much would relate to programs for the elderly, if you can give us that calculation. But we look forward to working with you. You have obviously got big challenges.

Mr. Chairman, I thank you for the chance to make this statement.

The **Chairman**. I thank you.

The chair recognizes Mr. Lightfoot.

STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

Mr. **Lightfoot**. Thank you, Mr. Chairman. I'd like to ask unanimous consent that my statement be made a part of the record.

The **Chairman**. Without objection, that will be the order.

Mr. **Lightfoot**. Mr. Secretary, welcome to our hearing today. I would just tag along with what my colleagues have said. I guess, in the old football metaphor, it looks like you have thrown a couple of touchdown passes over at HHS, and we hope that you are going to continue along those lines, and we offer our cooperation and willingness to work with you in the future, and we appreciate your being here today.

[The prepared statement of Representative Lightfoot follows:]

Jim Lightfoot

STATEMENT BY CONGRESSMAN JIM LIGHTFOOT
HOUSE SELECT COMMITTEE ON AGING - JULY 26, 1989
HOUSING FOR THE FRAIL ELDERLY

MR. CHAIRMAN, I AM PLEASED THE HOUSE SELECT COMMITTEE ON AGING IS CONDUCTING THE SECOND OF A TWO PART HEARING EXAMINING THE HOUSING NEEDS OF FRAIL ELDERLY. I APPRECIATE THE TIME SECRETARY JACK KEMP HAS TAKEN TO PRESENT THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT'S GOALS FOR MEETING THE NEEDS OF OUR NATION'S GROWING ELDERLY POPULATION. AS YOU KNOW I REPRESENT A LARGE ELDERLY CONSTITUENCY IN MY CONGRESSIONAL DISTRICT.

MORE LOW-INCOME OLDER AMERICANS PARTICIPATING IN FEDERALLY SUBSIDIZED HOUSING PROGRAMS, LIKE SECTION 202, ARE IN NEED OF CERTAIN SERVICES ENABLING THEM TO LIVE INDEPENDENTLY. THESE INDIVIDUALS ARE KNOWN AS FRAIL ELDERLY "AGING IN PLACE." FEW HOUSING CONTRACTORS IMPLEMENTING THE SECTION 202 PROGRAM HAVE ATTEMPTED TO LINK SERVICES TO ASSIST THEIR ELDERLY TENANTS IN NEED OF ASSISTANCE AS THEY AGE. INSTEAD, OLDER AMERICANS ARE PREMATURELY INSTITUTIONALIZED AT GREAT COST TO THEM AND OTHER TAXPAYERS. I SUPPORT GIVING SENIORS MORE OPTIONS TO MEET THEIR NEEDS.

SECRETARY KEMP, I WELCOME YOUR COMMENTS AND SUGGESTIONS AS TO HOW THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT WILL ADDRESS THE ISSUE OF HOUSING FOR LOW-INCOME OLDER AMERICANS AND HOW WE CAN COORDINATE CERTAIN SERVICES FOR THE FRAIL ELDERLY AND MAINTAIN THEIR INDEPENDENT LIFESTYLES. I COMMEND

YOU FOR PURSUING A COURSE OF ACTION COORDINATING SERVICES AND GOALS WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

IN ADDITION, I LOOK FORWARD TO THE COMMITTEE'S CONSIDERATION OF CHAIRMAN ROYBAL'S LEGISLATION, HOUSING FOR THE FRAIL ELDERLY ACT OF 1989. I UNDERSTAND THIS MEASURE CONTAINS A PROVISION EXPANDING TECHNICAL SERVICES FOR RURAL SECTION 202 CONTRACTORS. IN ADDITION, CONGRESSMAN ROYBAL'S LEGISLATION RECOGNIZES CASE MANAGERS CAN BE INSTRUMENTAL IN HELPING FRAIL ELDERLY IDENTIFY AND MEET THEIR EXISTING NEEDS.

THANK YOU MR. CHAIRMAN.

The **Chairman**. Thank you. he chair recognizes Mr. Kennedy.

STATEMENT OF REPRESENTATIVE JOSEPH P. KENNEDY II

Mr. **Kennedy**. Thank you, Mr. Chairman. Once again, it is a pleasure to welcome the Secretary. Your appearance today is a marked contrast to the number of times that our Housing Committee tried to get your predecessor to come and testify. I think the Secretary has been up to the Housing Committee on several occasions, and it is nice to see him here this morning.

Mr. **Kemp**. Thank you.

Mr. **Kennedy**. I am very interested, and, I think, picking up on Ron Wyden's comments, about the fact that you have had to suspend several programs. The 221(d)(4) program was a very important program to many of our Nation's senior citizens. You have made a commitment to improve these programs and get them cleaned up, but it is also very critical that we get them back on line.

I know that you have been very clear in pointing out that when these programs are suspended we are not going to use them to blame the victims, we are, rather, going to get them cleaned up and bring them back on line. I think it is important to continue to stress that over and over again.

Secondly, I think, just in a general sense, we have such a tremendous problem with our Nation's senior citizens when they hit the age of 65 or 70 or, as Mary Rose points out, 85, they find that the country basically turns its back on the tremendous needs that they have.

We have seen some innovative programs designed on congregate housing, and yet, as I understand it, today that program gets about $6 million worth of support from the Federal Government. There are many innovative solutions that different hospitals have designed for local communities, trying to hook up direct services that they can provide with elderly living in their existing homes. There is a range of new and innovative programs that exist out there. We don't seem to find the will as a Federal Government to give them the support they need. We have got just 16 percent of our Nation's poor senior citizens living in subsidized housing; there are over a quarter of a million of them that are on waiting lists around this country to try to get into affordable housing.

You are very familiar with these problems, Mr. Secretary, and you have demonstrated a real capacity to go out and reach out to people. These programs are expensive, they do cost money, but that generation of Americans really built this country up, and it seems to me that we just have to recognize that loyalty means something and that we really need to provide them with the kinds of support services that we hope that we will have when we hit that age.

So I know that that is your commitment, and I look forward to working with you towards those goals.

Mr. **Kemp**. Thank you.

Mr. **Kennedy**. Thank you. Thank you, Mr. Chairman.

The **Chairman**. Thank you, Mr. Kennedy. The chair now recognizes Mr. Schuette.

STATEMENT OF REPRESENTATIVE BILL SCHUETTE

Mr. SCHUETTE. Thank you, Mr. Chairman. Mr. Secretary—Jack—it's great to see you again, and we are all very pleased to have you here today.

I would like to insert my statement for the record as well, Mr. Chairman—

The CHAIRMAN. Without objection, that will be the order.

Mr. SCHUETTE. —and simply state, Jack, that I think your background and the sense of principle and fairness that you bring to your job here and your past strong stands on Social Security, and not touching that, and how important that is to all of us on the Aging Committee, is a statement and testament to your beliefs and that type of character you bring into your job.

So I am very pleased to be with you and will look forward to your comments.

[The prepared statement of Representative Schuette follows:]

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STATEMENT OF THE HONORABLE BILL SCHUETTE

HEARING OF THE SELECT COMMITTEE ON AGING
July 26, 1989

Thank you, Mr. Chairman. I want to take this opportunity to thank you for holding this hearing on housing for the frail elderly. I would also like to commend the fine work of my distinguished colleague, Mr. Rinaldo, on a matter of vital importance to those of us in this hearing, and millions of senior citizens around the country. I also want to express my sincere gratitude to the honored panelists for taking the time out of their busy schedules to share their insight and knowledge of the important issues of housing and services for the elderly.

Today we will be addressing the housing needs of this special group of elderly citizens, the frail elderly. In the 10th District of Michigan, the Federal commitment to elderly housing has been very important over recent years. Many low-income and handicapped elderly in mid-Michigan benefit from the Section 202 and Section 8 housing assistance offered by H.U.D.

We are all aware that the number of our nation's frail elderly will increase dramatically over the next thirty years, and it is critical that we provide adequate housing for these seniors. Those seniors who are "aging in place" are often in need of barrier-free housing, or modifications to their present housing, in order to maintain their activity and independence. While we must pay close attention to the affordability and availability of elderly housing, we must not overlook the characteristics of these dwellings and the services that may be provided to allow senior citizens to retain their independence and dignity. It is my sincerest hope that we can bring these issues to the fore during this hearing, and that our distinguished guests may provide insight and suggestions for this important matter.

Once again, I want to thank Chairman Roybal and Mr. Rinaldo for their attention to this significant issue of housing for the frail elderly, and I welcome our distinguished witnesses, the honorable Jack Kemp, Secretary of Housing and Urban Development, and Mr. Edward Kent, who will describe his experiences with housing needs. It is my sincere hope that the information conveyed in this hearing today will serve to highlight and strengthen the needs and programs of this nation's senior citizens.

Mr. **Kemp**. Thank you.

The **Chairman**. Thank you. The chair now recognizes Mr. Pallone.

STATEMENT OF REPRESENTATIVE FRANK PALLONE, JR

Mr. **Pallone**. Thank you, Mr. Chairman. Mr. Secretary, I just looked briefly at your statement, and I see that you are going to stress the need for the elderly to stay in their homes and that whatever Federal programs we have in place or we propose really have that goal of allowing the elderly to stay in their home or their apartment and live independently, and the whole idea of linking services to housing, to Federal housing, through congregate services or whatever is something that I very much support and that we have been trying to kind of add on to in New Jersey by even doing more, if you will, than what the Federal Government has done.

I just was hoping that at some point today you could address a program that I see linked to all of this, and that is the home equity conversion. I noticed during a previous hearing that this committee had that there is a home equity conversion mortgage interest insurance demonstration program, a kind of reverse mortgage program, that exists on the Federal level which, unfortunately, only has about 2,500 participants right now.

I know from my own experience with constituents in New Jersey, we have been trying to get people linked into this Federal demonstration program, and there is no bank in New Jersey that will now carry people who want to participate in that program; they have to go to New York or other States.

I was hoping that we could expand that program, that home equity conversion program. Just yesterday, I believe, Congressman Florio introduced a bill that would expand it to 25,000 participants. It is a bill that I have cosponsored. I think it is a way of linking a Federal program to what you have proposed, trying to keep people in place, living in their homes. One way of doing it is by encouraging home equity conversion. I don't believe it is really being effective right now on the Federal level, and I think there is more that we can do in that regard, and I was hoping that perhaps you could comment on that during your testimony today.

Mr. **Kemp**. Thank you. I will.

Mr. **Pallone**. Thank you.

Thank you, Mr. Chairman.

The **Chairman**. Thank you. The chair now recognizes Ms. Snowe.

STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Ms. **Snowe**. Thank you, Mr. Chairman. I just want to insert my statement in the record and welcome our former colleague and friend, Secretary Kemp. I am pleased that he is interested in the focus of this hearing today, which is linking housing and supportive services for the frail elderly.

Mr. **Kemp**. Thank you.

Ms. **Snowe**. Thank you, Mr. Chairman.

The **Chairman**. Without objection, your written statement will be inserted in the record at this point.

[The prepared statement of Representative Snowe follows:]

OLYMPIA J. SNOWE

"HOUSING FOR THE FRAIL ELDERLY: PART TWO"

HEARING BEFORE THE HOUSE SELECT COMMITTEE ON AGING
July 28, 1989

Mr. Chairman, I wish to thank you for calling this important hearing which examines methods for providing support services for the frail elderly in government subsidized housing projects. Such services play a critical role in assuring that older individuals are able to remain in the community.

Many residents of housing projects are "aging in place". These individuals moved in to housing projects ten to twenty years ago when the were elderly, and they remain there today.

Because the need for supportive services is linked to age, these elderly are more likely to need support services in order to maintain their independence. And with the aging of the population, there will be an even greater need in the future.

I am very pleased that my own state of Maine has been a leader in developing innovative social service and health programs for individuals residing in congregate housing. When the program was established in 1980, 22 percent of the original residents had previously lived in nursing homes or boarding homes. Through the program's efforts, these individuals were able to move back to the community.

Today, the program operates 20 sites and serves 200 individuals. A full range of services are provided including: meals, housekeeping, personal care and nursing services.

The aging of the population and the tendency for individuals to "age in place" have created a critical problem for many elderly in need of services and for housing project administrators. However, the situation also provides an important opportunity for directing needed supportive services to a large number of individuals in the community. As such, a comprehensive, congregate housing policy could play an even greater role in preventing premature institutionalization.

I believe that today's hearing is particularly timely. I know that Secretary Kemp has a particular interest in linking housing and supportive services, and I look forward to hearing his views on this issue. In addition, I also appreciate the opportunity to hear from Edward Kent about his first-hand experiences.

The **Chairman**. Now, Mr. Secretary, we would like to hear from you. I again welcome you on behalf of the committee and ask you to proceed in any manner that you may desire.

STATEMENT OF HON. JACK KEMP, SECRETARY, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, WASHINGTON, DC

Mr. **Kemp**. Well, first of all, Mr. Chairman, thank you for the welcome, your kind words, your friendship, and that of this committee. I think the bipartisan spirit on the committee on behalf of the frail elderly and the elderly in general is an important manifestation not only of the commitment of both political parties to helping our elderly, giving them the dignity and justice that they deserve, as has been mentioned in several of the opening statements, but also to recognize that, the demographics of the country have rapidly and are rapidly changing and that it is essential that we address the problems of the elderly in general and the frail elderly, to be specific.

I want to pay my respects, not only to you, Mr. Chairman, and to the members of the committee, but also to the empty chair that is reserved in perpetuity for Claude Pepper, the former chairman, for whom we all have high regard on both sides of the aisle. I had the opportunity recently in Overtown, Miami, the Liberty City/Overtown area of Miami, to announce a demonstration project called Operation Bootstrap, which was named after Claude Pepper and is involved in helping people with the type of services, housing support services, that Claude was known for and interested in and I know is also very much in the hearts and minds of the men and women of this committee.

It is highly proper that I report to the Committee on Aging because there is no member of the Cabinet who is aging faster than the Secretary of Housing and Urban Development. But I want to assure the committee that as we go about the Herculean task of cleaning out the Aegean stables—to use an historical metaphor—we are moving forward, and I feel quite confident, Mr. Chairman, that we can move forward on policies, programs, reforms, to meet the great goals of the Department of Housing and Urban Development given to us by the President, President Bush, as well as, I think, a bipartisan consensus that helping the homeless, helping move forward on affordable housing, helping encourage home ownership, particularly for first-time home buyers, to expand the opportunities for people in public housing to manage and control and ultimately own, if that is their choice, and also to implement fairly and vigorously the fair housing laws of America passed by the Congress, supported by President Bush back in the sixties, and I know a bipartisan spirit prevails on making sure that there is open housing in America to all people, irrespective of color, race, religion, or handicap of birth or handicap, physical, et cetera.

I also want to suggest, Mr. Chairman, that we have a development, and urban economic development, agenda. It is talked about in urban areas, but it is also for rural pockets of poverty as well. So I just want to assure the committee and assure you, Mr. Chairman, that I appreciate the chance to be with you. I particularly appreciated the kind comments from the Members on both sides of the aisle. I feel very much at home with you and, again, appreciate the wonderful support that this committee has given to the elderly and the frail elderly in particular.

I want to say that I know there are several bills that are supported and sponsored by members of the committee. The ones that I have looked at have noble objectives. I have looked at your bill, Mr. Chairman, and Mary Rose and I have talked, Joe Kennedy, and Ron have certainly been leading in this area, as well as members of the Republican party who have a profound concern for the elderly as well as the frail elderly; Senators Cranston and D'Amato.

I think the goals of bringing together the services and linking them to the elderly and to the frail elderly in particular are absolutely essential to providing the type of dignity and opportunity for senior Americans to continue to contribute to this great Nation of ours.

I think someone mentioned the section 202 program. I had the opportunity recently, when I was visiting Philadelphia, to stay in Dr. Leon Sullivan's Opportunities Industrialization Center, Senior Citizen 202 Housing, in North Philadelphia called Opportunities Tower. I was impressed, Mr. Chairman, with the tremendous work of that program in general and, of course, Dr. Sullivan's Opportunities Industrialization Center approach to senior citizen housing.

You can be assured, Mr. Chairman, that this is a Secretary of Housing and Urban Development who shares the committee's goals, who shares the committee's ideas for linking housing to services and also making sure that the elderly have an opportunity to be independent and to provide those opportunities for them to remain in their own homes, if that is their choice, with the maximum amount of Federally assisted support services.

Many of the supportive services, Mr. Chairman, so needed by frail elderly do come directly from HHS as well as States and localities, the private sector—churches, synagogues, nonprofit neighborhood groups—et cetera. I want you to know, Mr. Chairman, that I personally believe that Social Security and Medicare and Medicaid and title III of the Older Americans Act—are the bedrock of security for elderly and poor Americans.

I appreciated Mr. Schuette's suggesting that I was a strong supporter of not touching COLA's, I know the committee has been, and I think it is a tribute to the administration and to the Congress in a bipartisan way that no one, I think—no one that I know of is talking about reducing COLA's in order to achieve budget restraint.

I think it is becoming increasingly clear, Mr. Chairman, that inflation is not caused by senior citizens, inflation is not caused by people working, inflation is not caused by the American people wanting to live in decent and affordable housing; inflation is a product of the Government's failure to maintain the value of its currency. It begins and ends on the issue of monetary policy, and, as I said before, I do not favor and have never favored removing a COLA—a cost-of-living allowance—from a senior citizen as a way of meeting budget goals.

I want to add one thing at this point. I hope the earnings retirement test is removed soon. I have long felt as a Member of the Congress that seniors have much to contribute to this country. It is obvious that there is going to be a labor shortage. But for many reasons, it seems to me, the earnings retirement test should be repealed. It has been a barrier to the contribution that seniors can make to the national economy as well as to their own economy, as well as to bring dignity to their senior years.

As the Secretary of Housing and Urban Development, I come in contact with the needs of the elderly in so many ways. Today, 36 percent of voucher and certificate holders are elderly citizens. By the year 2000, the frail elderly population living in assisted housing, as I think was pointed out by one of the Members, will increase by a third at least.

It seems to me, Mr. Chairman, that we face some real choices. The elderly can be helped, as Mr. Wyden pointed out, to stay in their homes that they have lived in for many years in the neighborhoods where their friends and families reside, in the communities where they feel a sense of security and belonging, but without extra help some elderly folks facing needs in this area with daily living could be forced to leave their homes, become prematurely institutionalized in our hospitals and nursing homes at great cost to society and to them and to the Government budget.

I hate to put these things in budget terms because I don't think it is primarily a budget issue. There are implications for the budget, but most important is the dignity and the justice and the opportunity for seniors to continue to contribute to their own lives as well as to the lives of the community.

My own opinion on this matter has been made clear. I want low-income elderly who are living in public and Federally-assisted, HUD-assisted, housing to stay, to have access to the type of services and care that will help them be self-sustaining.

I'm kind of editing as I go along to shorten it up, Mr. Chairman, but skipping to page 5 of my testimony, I personally, as I pointed out, have seen how public-private partnerships in HUD's 202 Housing Program can raise the spirits and morale of elderly people.

I mentioned that I stayed in Dr. Sullivan's Opportunity Towers senior citizen housing in Philadelphia. It was really an inspiration. I did very early on; I did it in February, right after I was sworn in, Mr. Chairman, and it has stayed with me. It has given me a sense, as I have tried to get around the country and visit different cities and urban areas of America—it really did give me both an existential impression as well as a visible manifestation of what we can do for seniors when there are these positive and progressive public-private partnerships.

I don't need to tell you, Mr. Chairman, that the whole notion of supportive services in public housing communities and Federally-assisted properties is at the cutting edge of our future in this country, particularly for seniors. I want to take the opportunity not just to discuss HUD's plans for the frail elderly but, with your permission, some goals and hopes to expand the range of services for all populations in need, to give poor people and needy people access to a broad range of social, transportation, and job training services.

This goal that has been mentioned by the committee and you, Mr. Chairman, and was manifested in the Cranston-D'Amato bill, as I mentioned, and your bill as well, this goal of linking up services with housing is based upon our common belief that Federally-assisted housing must not be seen a warehouse, must not be seen as a staging area for poor folks, or the elderly, or the forgotten areas of the city where people are not to be heard from again.

We at HUD are absolutely committed, Mr. Chairman, to working with this committee and the Congress to assuring poor people access to supportive services, and particularly our goal is to support policies that would help poor people move to self-sufficiency with jobs, job training, child care, transportation, would give the homeless access to mental health and substance abuse treatment.

I have long felt that some of the editorials in the New York Times in which they talked about mental health vouchers for the homeless and people who need mental assistance would be a new way to go, and we are going to demonstrate at HUD in this area where we want to tie together the supportive services for those who are in need of treatment for physical or mental problems, or chemical abuse problems, and tie it to the voucher.

It is obvious that right here in Washington, D.C., where you have some folks living in a welfare motel that just to give someone a voucher and get them the housing and then leave them without a service is a sham really, and we are not going to operate in that way under our leadership at HUD.

We want to encourage resident management, as I pointed out before, in home ownership. We want to encourage local communities to offer comprehensive antipoverty strategies, Mr. Chairman, such as in the Operation Bootstrap that we announced in honor of Claude Pepper, who had talked to me for several weeks and months prior to his passing. We want to offer innovative policies to help the frail elderly and other special needs populations to remain self-sufficient.

We don't have a whole lot of experience to rely on in this area. The costs might be large and would continue over a long term. We have a small congregate housing service program, CHSP, at HUD for public housing, the 202 projects. We are trying to improve it, and we want to improve it even more by targeting the people in need, and I want to say to Congressman Kennedy, Joe, we are going to reopen that program for the senior retirement service centers, but we want to target it to the people who are in need; we want to make sure that it is using Federally-raised tax resources in a way in which the taxpayers of America can feel certain that it is going to people who are in need, not to those who are at a higher level of income.

Originally, the FHA Insurance Program for Retirement Service Centers was designed primarily for people 65 years of age or older who can live independently and pay market rates. The project, as I pointed out, turned out to be too expensive, so we are just reevaluating how we can end the defaults that were mounting alarmingly. But it is going to be reopened, retargeted, tightened up, just as we did under the Mod/Rehab program.

In the few months I have been at HUD, we have already given a lot of thought to how we can better help the elderly in Federally-assisted housing. I have directed my staff to begin an open line of communication not only with the committee, as my appearance here today reflects, but also with the Department of Health and

Human Services. We want to establish a memorandum of understanding, a very close working relationship, with Lou Sullivan at HHS, not unlike what we are trying to do in the Interagency Council on the Homeless which I chair.

I am not ready today, Mr. Chairman, to announce sweeping or wholesale changes, but we are looking at how 202 programs can be better made to accommodate supportive services in congregate care, how vouchers and services could be combined, how services might be expanded in Federally-assisted housing that are targeted to the frail elderly.

We are going to give top level attention to this at HUD, Mr. Chairman. I am appointing a special assistant in the Office of Housing to provide oversight, policy guidance, and coordination, and interface with this committee and with HHS in the area of supportive services for the frail elderly.

I am sure that many of you have been concerned about delays in the 202 elderly housing program. I just want to assure you, Mr. Chairman and the members of the committee, I was shocked to discover that because of previous HUD policies 30,000 or more elderly housing units, all of which had been funded, had never left the architect's drawing board. Some of these projects have languished since 1985, and I have ordered a speedy review, a study of the policies that caused the delay, and after review with my appointees, we will take immediate action to get this clog out of our pipeline and to move forward on this very important program.

Programs must be designed that allow the elderly to choose where they want to receive their services. For elderly who are renters, there are two options which can be made available to them. A congregate setting might be useful in certain circumstances, but for those who want to remain in their own home, it may be a voucher that can be funded at a higher level; that might give them access to needed services. I don't have any hard and fast, concrete rule about vouchers. I think they can be useful, they can be a tool, they can tie together services, but I want to give a number of options to senior Americans.

HHS is currently conducting a demonstration on using social health maintenance organizations, S/HMO's, to provide health and long-term care services in community-based settings. They are similar to HMO's in their operations. They charge a set fee, paid in advance, for a wide variety of services. The results are not in, but I think it can provide a means to overcome this challenging responsibility that we have.

The costs for these services must be shared between the Federal Government and the States. The States have a variety of funds, including social service block grant, title III of Older Americans, Medicaid, general revenues, and States need to be asked to share these costs. I'm not trying to dodge the Federal responsibility, Mr. Chairman, but States can also be at the front line of sharing the responsibility for their own residents.

Third, elderly recipients of services must be responsible for paying, where they can, for part of their services, if they can afford it. The Robert Wood Johnson Foundation's demonstration on supportive services, which we are actively supporting, Mr. Chairman, for older people has found that the elderly are, in many cases, willing to pay for services which would enable them to remain independent. The Foundation has noted that the resources of the elderly who are poor may be more limited than those in their demonstration, but the Foundation has refused to dismiss the idea of some type of a copayment. It can be considered as we go forward.

Fourth, elderly projects should be better designed. I know this committee has a concern about the design of elderly projects that can help facilitate congregate activities. Previous witnesses before this committee have suggested that the requirements for cost containment in 202 and the individual size of the project approved may inhibit inclusion in certain cases of congregate facilities. I have asked my assistant secretary for housing to reexamine our 202 program to ensure that the program itself does not discourage the use of congregate services for frail elderly.

Fifth, we must target our limited resources to those elderly most in need. The history of CHSP, the Congregate Housing Service Program, has been one of increasingly tighter individual eligibility requirements. Originally, an elderly person had to demonstrate that he or she needed assistance with one activity of daily living. Currently, the program requires participants to need assistance with three or more of these activities. I regret the necessity of limiting our resources to the most incapacitated or the frailest of the elderly, but I want you to know, Mr. Chairman, I want to work with you and the Congress to assure that our programs for frail elderly are not only cost-effective but are fair and comprehensive.

Finally, case management is something you have been concerned about, Mr. Chairman. I want to commend your bill for recognizing the true role that case workers can play in organizing services and tailoring them to those in need. There is a question about savings, but a full-time case manager can ensure that the program is being offered to those who need it, that the services that are provided to an individual match the person's need. A case manager, as you put it, Mr. Chairman, can help the frail elderly navigate his or her way through a seemingly formidable legal service delivery system and can also negotiate with providers to secure the services that are needed at reasonable cost.

Mr. Chairman, it is an exciting time to be where you are. I think it is an exciting time to be where I am. Let me make just one final pledge to you that I made at the beginning of my testimony. We want to work with you and the committee. We want to move forward on the reform that we want to pledge to the committee, as I pledged to Chairman Lantos and to Chairman Gonzalez, and I want to pledge to Chairman Roybal and to the bipartisan spirit of this committee, we are going to clean up HUD, make it work, while moving forward on the goals that Congress and President Bush have outlined for those of us at HUD in the next 4 years.

Thank you for your attention, and I look forward to doing my best to answer your questions and being responsive to your concerns.

[The prepared statement of Secretary Kemp follows:]

STATEMENT OF JACK KEMP
SECRETARY
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
BEFORE THE
HOUSE SELECT COMMITTEE ON AGING
JULY 26, 1989

Mr. Chairman and Members of the Committee:

It is a pleasure to appear before you today to discuss the housing needs of America's elderly. I want to begin by saluting the lifelong efforts of the former Chairman of this committee -- Representative Claude Pepper -- for his unparalleled efforts to help elderly people achieve their full potential and human dignity. In my visit to Overtown, Florida, I offered Operation Bootstrap in honor of Representative Pepper. It seemed only fitting that this idea of combining housing with anti-poverty initiatives should be associated with a man who devoted his life to helping others.

I also want to mention our support for the goals of the Cranston-D'Amato bill in the area of the elderly and handicapped. I believe that we can work with your Committee and the Housing Committee and others in both the House and Senate to assure that housing programs are effectively linked with supportive services and in communities across the nation.

The measure of a compassionate society is how well it treats those who are most vulnerable. Your longstanding concerns Mr. Chairman, with some of our Nation's most vulnerable citizens, our frail elderly, is a tribute not just to you and this Congress, but to the type of system we hope to create and preserve in our country--communities which care for each and every person. The Good Shepherd reminds us that we must move everyone forward together, leaving no one behind.

Your bill, Chairman Roybal, begins to address this problem by giving elderly in federally-assisted housing more access to support services and that sense of dignity which is so important to every American.

Many of the supportive services so needed by the frail elderly come directly from the Department of Health and Human Services as well as the states, localities, private sector, and non-profit neighborhood groups. I want you to know Mr. Chairman, that I personally believe that the Social Security system, Medicare, Medicaid, and Title III of the Older Americans Act are the bedrock of security for elderly and poor Americans. I know you would also joint with me in wanting to guarantee full indexing of Social Security benefit checks for inflation. And I think it is a tribute to this Administration and the Congress that there has not even been a hint of touching COLAs to help meet our budget goals.

As Secretary of Housing and Urban Development, I come into contact with the needs of the elderly in many ways. Today, 36% of Voucher and Certificate holders are elderly people. By the year 2000, the frail elderly population living in assisted housing will increase by about 33%.

Now, it seems to me, Mr. Chairman, that we face some choices. The elderly can be helped to stay in the homes that they have lived in for many years, in the neighborhoods where their friends and family may reside, in the communities where they feel a sense of security and belonging. But without extra help, some elderly people facing need with daily living could be forced to leave their homes and become prematurely institutionalized in our hospitals and nursing homes, at great cost to our society and government budget.

Mr. Chairman, my own opinion on this matter is quite clear. I want the low-income elderly living in public and federally assisted housing to stay and have access to the type of services and care that will help them be self-sustaining and independent.

The frail elderly need different kinds of services. Some of the frail elderly may only need to help with meal preparation, dressing, or housekeeping. Where these services are not readily available to individuals who cannot manage for themselves, they may have to go into a nursing home. Nursing homes provide a higher level of care than many elderly need, making them an economically unsound option for many. But more than that, they are often unattractive places to live. They create isolation, removing the elderly from the communities they felt comfortable and secure in. Housing options can and should be offered that prevent this premature institutionalization.

Now, I'm not saying that only those living in their own homes can achieve that feeling of pride and hope in the future. Thankfully, we have quality nursing homes and hospitals for those who truly need those services. It is also fortunate that states, localities and the private sector have been developing innovative approaches to provide a range of home and community-based services for low income elderly persons. In 1989, states and localities are spending an estimated $5.1 billion for such services, much of it federally-funded. But I think most Americans would agree that there is still a gap between the current alternatives of totally independent living arrangements and the comprehensive care offered in a nursing home.

I have seen personally how private-public partnerships in HUD's 202 housing programs can raise the spirits and morale of the elderly. Recently, I had the pleasure of visiting and staying overnight in Leon Sullivan's Opportunity Towers in Philadelphia, and it was a true inspiration to see the tremendous work he is doing. More than 600,000 elderly live in Section 202 housing and public housing alone, and this population will continue to grow and continue to age.

There's another reason to help the frail elderly in our housing communities; simple economics. I don't have to tell anyone here that nursing home and hospital care are enormously expensive. When the elderly in public and federally-assisted housing are prematurely forced to enter a hospital or nursing home, the cost of Medicaid or Medicare may be more expensive than providing limited care or service targeted to the most vulnerable frail elderly in the housing community itself.

I don't need to tell you, Mr. Chairman, that this whole notion of supportive services in our public housing communities and federally-assisted properties is really at the cutting edge of the future. And I want to take this opportunity not just to discuss our plans for the frail elderly, but with your permission, my hopes and goals to expand the range of services for all populations in need, to give more poor and needy people access to a broad range of social, transportation, and job training services.

This goal of linking up services with housing is based on my belief that federally-assisted housing must not be seen as a "warehouse" for poor folks and the elderly -- as the forgotten areas of our cities where people are never heard from again, except in crime statistics or drug busts or welfare rolls. Our poorest citizens must not be condemned to despair and hopelessness, closed off from making their own contributions to society.

We at HUD are absolutely committed to assuring poor people access to supportive services so that they can truly enjoy the economic opportunity, jobs, and dignity which is the dream of all Americans. In particularly, my goal is to support policies that would:

-- help poor people move to self-sufficiency with jobs, job training, child care, and transportation;

-- give the homeless access to mental health and substance abuse treatment to meet the challenges of daily life;

- -- encourage resident management and homeownership with technical assistance and management training where tenants have shown an interest to take over the operation of their communities;

- -- encourage local communities to offer comprehensive anti-poverty strategies through our Operation Bootstrap initiative.

- -- offer innovative policies to help the frail elderly and other special needs populations to remain self-sufficient.

In short, our inner cities must be turned into vibrant neighborhoods where people can raise their families, educate their children, live in a safe drug-free neighborhood, have opportunities for good jobs, and look forward to a secure retirement in old age. Housing alone will not empower the poor or create a sense of community. We must attend to their other needs as well.

We don't have much experience to rely on in this area for a comprehensive program. And because costs could be quite large and would continue over the long-term, we should be prudent in our programs. The small Congregate Housing Services Program (CHSP) for public housing and 202 projects has been greatly improved by targeting it better to those in need. Other programs have experienced problems.

Originally, the FHA insurance program for Retirement Services Centers was designed primarily for persons of 65 years of age or older who can live independently and pay market rates for services provided. But the projects turned out to be too expensive for most of the elderly -- only 1/4 of them can afford the housing and services. As a result, buildings were slow to fill and defaults mounted alarmingly. We are currently evaluating this program to determine if it can be redesigned so that it produces housing for those who need it, rather than producing empty buildings and losses as experienced in the past.

But there is no excuse for not trying new and innovative approaches that are economical and helpful to the frail elderly themselves, and supportive of that type of community atmosphere we hope to foster.

In the few months that I have been at HUD, we have already given a lot of thought to how we can better help the elderly in federally-assisted housing. As a first step, I have directed my staff to begin an open line of communication with the Department of Health and Human Services, with the goal of establishing a

Memorandum of Understanding to coordinate their supportive services with HUD's elderly housing. The Interagency Council on the Homeless accomplishes some of these same goals for the homeless; I think it's time we begin doing the same for the elderly.

While we are not yet ready to announce sweeping changes, we are looking at how the 202 program can better accommodate supportive services and congregate care; how vouchers and services might be combined in one package; and how services might be expanded in existing federally-assisted housing targeted especially to the frail elderly.

To assure that this effort receives top level attention at HUD, I am appointing a Special Assistant in the Office of Housing to provide oversight, policy guidance, and coordination with other Federal agencies in the area of supportive services for the elderly.

I am sure that many of you are concerned about delays in the Section 202 elderly housing program. Let me assure you that I was shocked to discover that because of previous HUD policies, almost 30,000 elderly housing units -- all of which have been funded -- have never left the architect's drawing board. Some of these projects have languished since 1985. I have ordered a study of the policies causing the delays and after review with my appointees will take immediate actions to attack the "clog in the pipeline." I intend to serve notice that this Department is serious about moving the Section 202 pipeline in a reasonable and responsible way.

Several policy principles will guide the development of this Department's new approaches for the frail elderly.

First, programs should be designed that allow the elderly to choose where they want to receive these services. As one example, the elderly who are homeowners can use HUD's new Home Equity Conversion Mortgages to use the equity in their home for funds to purchase services.

For the elderly who are renters, there are two options which could be made available. A congregate setting might be useful in certain circumstances; for example, for dining and meal preparation and recreation. But for those who want to remain in their current dwelling, a housing voucher funded at a higher level could give elderly access to needed services.

There are doubts about the ability of the frail elderly to access and intelligently use local supportive services delivery systems. HHS is currently conducting a demonstration on using Social/Health Maintenance Organizations (S/HMOs) to provide health and long-term care services in a community-based setting. S/HMOs are similar to Health Maintenance Organizations in their operations, charging a set fee paid in advance for a wide variety of services. While the results of the demonstration are not all in yet, we look forward to seeing whether the demonstration will provide a means to overcome these challenges.

Second, costs for these services should be shared between the Federal and State governments. States have a variety of funds including Social Services Block Grant, Title III of Older Americans Act funds, Medicaid, and general revenues which could and are currently being used for this purpose. States should be asked to share in these costs because they will probably benefit from any net savings in their Medicaid expenditures, and States should also be on the frontlines of sharing this responsibility for their own residents.

Third, elderly recipients of these services should be responsible for paying for part of these services, if they can afford it. The Robert Wood Johnson Foundation's demonstration on supportive services for older people has found that the elderly are willing to pay for services which would enable them to remain independent. The Foundation notes that the resources of the elderly who are poor may be more limited than those in their demonstration, but the Foundation refuses to dismiss the idea of a copayment even among the poor.

Fourth, elderly projects should be better designed to facilitate congregate activities. Previous witnesses before this Committee have suggested that the requirements for cost containment in the Section 202 program and the individual size of the projects approved may inhibit the inclusion of congregate facilities, such as dining rooms, in the building design. I have asked my Assistant Secretary for Housing to reexamine our Section 202 program to ensure that the program is not discouraging the use of 202 congregate services for the frail elderly.

Fifth, we must target our limited resources to those elderly most in need. The history of CHSP has been one of increasingly tighter individual eligibility requirements. Originally, an elderly person had to demonstrate that he/she needed assistance with one activity of daily living. Currently the program requires participants to need assistance with three or more of these activities, one of which must be eating or preparing food. I regret the necessity of limiting our resources to the most incapacitated of the elderly. I pledge to work with the Congress to assure that our programs for the frail elderly are cost effective, fair and comprehensive.

Finally, case management is a vital component in any program which provides services to the frail elderly. I commend the Chairman's bill for recognizing the true role that caseworkers can play in organizing services and tailoring them to those in need. While there is a question whether it would save money, a full-time case manager can ensure that the program is being offered to those who really need it and that the services that are provided to an individual matches that person's needs. A case manager can help a frail elderly navigate his or her way through a seemingly formidable local service delivery system. A case manager can also negotiate with providers to secure only services that are needed at reasonable costs.

This is an exciting time. We are in the forefront of helping to change the destiny of the poor, the homeless and the elderly. We look forward to working with Congress on ensuring that our plans become a reality.

This concludes my testimony. I would be happy to answer any questions you have.

The **Chairman**. Thank you, Mr. Secretary.

I'm very pleased to know of your willingness to work with the Congress of the United States in making possible a program designed to take care of the problems for the elderly.

Mr. Secretary, you articulate a number of essential points to improving safe and independent housing for the elderly. I would like to commend you, first of all, for your appointment of a special assistant to provide oversight and policy guidance in the area of supportive services for the elderly but also commend you for a memorandum of understanding with HHS. Those are real steps forward, and I think that a great deal can be accomplished, but it needs, of course, your constant effort to make things happen, and we are here to help. We want to work very closely with you so we can make you the most successful Secretary of HUD that we have ever had, and I am sure that that will be the result.

I am concerned, Mr. Secretary, about the fact that in the last 8 years the HUD budget was reduced by over 80 percent. The section 202 budget has been reduced from 21,000 new units to 8,500 units this year. We are falling drastically behind in the need for housing. What is your plan, Mr. Secretary? How are you going to address yourself to this particular problem?

Mr. **Kemp**. Well, as you have pointed out, Mr. Chairman, the budget for new construction reflected so dramatically in the drop in budget authority over the last several years, in my view, Mr. Chairman—and I say this with good will for the question and the sincerity behind the question—does not reflect the total picture.

It is true that the budget authority for new construction—and I am not now talking just about 202 but generally has dropped. There has been, at the same time, a concern to shift some of the resources from new construction to direct assistance to the tenants.

I have said many times I don't want to be the Secretary of Vouchers, I want to be a Secretary of Housing and Urban Economic Development. I think most Members on both sides of the aisle have accepted my pledge and the good will that is reflected in the Bush administration for trying new things.

But I do want to make clear that I think it is very important that we recognize that the budget for outlays, direct assistance to tenants, has gone from about $5–6 billion in the early eighties to $14–15 billion here in fiscal year 1989. That is not the total picture either.

I tried to tell the Budget Committee when I first testified before them, Mr. Chairman, that if we were simply to look at HUD from the standpoint of whether Kemp was successful or not successful or whether the next Secretary is successful or not, you cannot look only at BA because it doesn't give quite the picture that you would have to have.

My hope is that we can have a public-private partnership. My hope is that we can encourage and incentivize housing through the tax system. My hope is that we can move quickly on the LITC. I hope that we can move quickly on new legislation that would encourage nonprofits. I would hope that we could encourage States and the Federal Government to do more to help the tenants directly, and particularly to rehabilitate the existing stock.

I am convinced that there are thousands upon thousands upon thousands of existing units in our stock that can be rehabilitated, and modernized, and brought back into usage.

This is not to escape the responsibility that I have for being a Secretary of Housing, but I believe strongly the point you made, the one program that we do have for new construction is in 202, senior citizen housing. It was a profound experience to spend time in a 202 project in Philadelphia, and we are going to be a fighter for that program, and we are going to hopefully break up that clog that exists in the pipeline, and I just want to pledge to you, Mr. Chairman, we think we can do a lot better job than has been done in the past number of years in many of these areas.

People say, "Well, Kemp, don't overpromise," and I don't want to overpromise, but I do promise to you and pledge to you that we are going to be an activist agency, and we are going to be a catalyst for change and reform, and we are going to be a catalyst and an activist agency on behalf of expanding this whole area of supportive services for the elderly and the frail elderly in particular.

The **Chairman**. Thank you, Mr. Secretary.

As you know, we are now under the 5-minute rule, and I have about a minute and a half left of my 5 minutes. However, I would like to ask you a very quick question because I think it is most important that we get your opinion with regard to this. How would the voucher system for mental health services for the elderly living in low-income housing work?

Mr. **Kemp**. Conceptually—and that is at the stage it is currently being promoted or advanced, Mr. Chairman—it would be a service voucher. It would be a voucher that would tie together the assistance in housing with the assistance and the needs of those who need supportive services.

So rather than just tell a person, "Here's your voucher; go out, and you're on your own," which in some cases might work for a younger person, this would tie together at the local level services that are needed and your effort on behalf of providing an extra dimension to the service—i.e., a caseworker—seems to me to be a very positive and compassionate idea with regard to tying in the voucher to the services and the caseworker and the effort that could be made at the community level to give people the dignity and the service that they need simultaneously, Mr. Chairman.

The **Chairman**. Thank you, Mr. Secretary.

As you know, there is a Committee on Appropriations, and it is meeting at the present time, and I've been called there for a vote. However, this hearing will continue. The chair now recognizes Mr. Rinaldo for a series of questions. Mr. Rinaldo.

Mr. **Rinaldo**. Thank you, Mr. Chairman.

I want to, first of all, commend Secretary Kemp for his testimony, his plans, and his ideas.

One of the things you said in your testimony was that it is hard to put these things in budget terms, but that is the reality. Our elderly population is certainly growing rapidly, and we are going to face the same budget constraints that we are facing now well into the future.

Is there some method of shifting part of this burden? You spoke, for example, of public-private partnerships. You spoke about rehabilitating existing housing stock. You spoke about offering innovative policies. But what are the workable, practical alternatives to purely public financing for housing? How do we stimulate the private sector? How do we provide incentives? For example, when you mentioned urban areas, in my home State of New Jersey, I don't know one builder who is building housing in the urban areas, in the cities. They say it isn't practical. How do we do that and get the kind of housing stock that we need in this country?

Mr. KEMP. Let me say to my friend from New Jersey, with whom I have worked very closely over the years on so many things, and having been in his own district and in the State of New Jersey several times, I am absolutely convinced that the tax code has to be social policy driven.

Some people on my right get nervous when Kemp, who has been known, hopefully, as a tax reformer, who cooperated with Bill Bradley and Dick Gephardt, who cooperated with the White House in trying to reform the code—I know I make some people nervous when I go back, or seem to go back, on the pledge to bring reform by clearing out some of the credits and some of the, frankly, garbage that was in the tax code prior to 1986.

But I think it is not inconsistent, I don't think it is a paradox, to suggest that you can both bring down the rates of taxation to encourage economic growth and entrepreneurship and job development in America and still have a tax code driven by some socially desirable goals—i.e., economic development, job development, in poor areas of America, as well as housing in low-income communities and for low-income people.

So I would suggest to the gentleman from New Jersey—and I hope it is taken in the spirit in which it is offered—I am not the Secretary of Treasury; but I think the tax code has to reflect the desire and the commitment of America to develop its low-income communities as well as to help house the elderly and particularly low-income people.

So you have got to have, first of all, a tax system that encourages the investment of capital and seed corn and oxygen, if you will, into the body economic that would apply to the low-income communities and low-income people of America.

I have seen the work—and I know the gentleman has, as well as other members of the committee—of the nonprofits in America. They are doing an unbelievable job. We need to incentivize them, encourage them, and recognize they are a tremendous resource. They are not the sole answer, but they are a great resource. They are doing great work all over the country—church-based, Synagogues, Enterprise Foundation, Jubilee Housing, Millard, Fuller, Habitat for Humanity—they are just a myriad of organizations, and they need to be encouraged. There is someone out here in Northern Virginia, Virginia Peters' organization called the Wesley Foundation's Housing Corporation. I was over there the other day, and it is remarkable. So they need to be incentivized.

We need to cut out some of the restrictions on zoning and Government regulations that inhibit it, and then I need to unclog the pipeline that has got over 30,000 units of senior housing. The Federal Government has a responsibility to directly fund certain elements of this, our States are going to have to be involved, and we have got to have an all out commitment, as Mr. Rouse pointed out, to have affordable, and fit, and decent housing for all Americans by the turn of the century. I want to be that type of a HUD Secretary, but I want to do it without resorting to some orthodoxy of just having the Federal Government construct it all, because I think there is such a great role to be played by the private sector as well, carefully monitored, of course, as it was not done in the past.

Mr. **Rinaldo**. Thank you.

I find myself in the same position as the chairman. I have about a minute and a half left. I'd like just to go back to one point you mentioned that I am particularly interested in and I think is an exceptionally good point.

You mentioned reform of the tax code. When we did reform the tax code, it has been alleged that we took out the incentives to provide the kind of housing that you and I both want in our urban areas.

Mr. **Kemp**. Right.

Mr. **Rinaldo**. Could you, in a minute or so—very briefly—tell the committee what kind of changes you would like to see, specific changes in the tax code, to provide the incentives that are so desperately needed for building to once again begin in our urban areas in particular?

Mr. **Kemp**. I think in the area of the Mitchell-Danforth tax credit report I would strongly favor, as I testified before Chairman Rangel's subcommittee of Ways and Means, for making the LITC permanent.

I have talked with Congressman Kennedy about the great needs in the area of preservation, how we can use the tax code to include the preservation of the existing stock.

I would have some other views about capital gains, about passive loss, but I would probably trespass on a lot of other people's portfolios. So I think the first thing we can do is have a positive, progressive, carefully monitored low-income housing tax credit, make it permanent, and don't put it on, take it off. It's silly to put on something like that and then take it off and tell people that you are going to jiggle the tax code for 1 year or 2 years and try to get folks to do something that should be done as social policy and economic policy in America.

Mr. **Rinaldo**. Thank you very much.

Ms. **Oakar** (presiding). Thank you very much.

Mr. Secretary, I understand you have to leave by 10 to 11, so maybe we could do 3 minutes for each of us. Would everybody agree? I am going to ask unanimous consent that we do that, and let me adhere to my 3 minutes.

Mr. Secretary, it seems to me that you have two ominous responsibilities. One is over the subsidized housing programs, and one is for those who don't live in public housing and who are near poor, and I know you have a concern about this.

For the subsidized housing programs, we have a seen reduction from 21,000 units for 202 to 8,000 in the last 8 years, and you are under some restrictions there, but I think the fact that you are looking at the modernization program is very key.

You know, you ask anyone from older areas like my own—and many of us are from these areas—and we will tell you where all the boarded up units that are still structurally sound are. How does paying for those units, paying the housing authorities for units that are unoccupied—wouldn't it be nice if HUD paid the subsidy for units that are occupied? I think that is a way to make up for some of the problems you have budget-wise in terms of units. It doesn't take its place, but I think that is a very good sign.

On the other hand, you have many people in housing who are older who own their own homes, whose kids have moved out. They own these big homes with three bedrooms and a couple of baths and so on. They want to stay there, but they can't afford to stay there.

I was struck by your comment, Mr. Secretary, that you had observed since your tenure 30,000 units that were in the pipeline to be built since 1985 that aren't built, for whatever bureaucratic reason, and I know you are really cleaning all that up, and I don't want to dwell on that because I think that is not the purpose of this hearing.

But I had introduced and had passed a shared housing program where people who lived in their own homes could have other people who got a voucher—and I'm not a terrific fan of voucher programs, but I think there can be some use of them—who got a voucher, and then they could live in the same home with the older people who wanted to stay in that home, and you have two or three or four or five occupants, and we passed it, and do you know that HUD never put out guidelines for the shared housing program that we passed and so we never were able to see whether it work or not? You have got that situation where near poor people own their own homes and other poor people would love to live in that home with those poor people.

Along with your outstanding appointment, I think, of a special assistant to oversee these support services, the memorandum of understanding with HHS, is that something that you could take a look at? You see, we all have these innovative—we think they are not fantastic, grandiose ideas, but they are new concepts that we ought to take a look at. The chairman has introduced a bill that is a kind of new concept.

I mean I would like to see you come forward with a pilot project that is comprehensive, that says we are going to try some new ideas and some old ideas and shake things up a little bit, and I think you are the guy to do it, if you don't mind my using the vernacular here. Is that something that you could hang your hat on or take a look at?

Mr. **Kemp**. Mary Rose—if I can call you that—

Ms. **Oakar**. Sure.

Mr. **Kemp**. —as somebody who has come down to HUD, and visited with us, and had a chance to visit with me not only about this issue or other issues of housing in her own area but also on behalf of economic development, which I was grateful for—

Ms. **Oakar**. We are going to do that, too.

Mr. **Kemp**. I appreciate that.

I would just say to the gentlelady from Ohio that I strongly agree that it is a good idea, that we would like to experiment and demonstrate and pilot project some of these ideas.

Talking about the near poor, having folks somehow voucherized to live with them could be part of our overall hope of a service-oriented voucher that would provide an opportunity for the near poor to have that type of assistance and that type of living atmosphere. It is a good idea. It is a good idea, and I would like to explore it with the gentlelady from Ohio.

We don't think we are the repository of all ideas, and I appreciate very much appearing before the committee where, as you pointed out, making modest changes in some programs can lead to some rather enormous benefits for the elderly.

Ms. **Oakar**. That is right, and you have always been a very strong supporter; I recall this in the past, that you were a strong supporter of Social Security.

I just want to add, because we are in this room where we do a lot of hearings on Federal employees, and I have chaired many hearings in this room on that behalf, civil servants and military retirees are those who sometimes get left out with cost-of-living formulas, and I have always been pleased that you have been supportive of retaining cost-of-living adjustments for all seniors and not just Social Security recipients, because they have some needs too.

Mr. **Kemp**. Thank you.

Ms. **Oakar**. But you are on the road, and I just hope you don't stop in terms of innovation and trying things out, and don't let us handicap you in terms of going forward.

Mr. **Kemp**. Thank you.

Ms. **Oakar**. Congresswoman Snowe.

Ms. **Snowe**. Thank you, Madam Chairwoman.

Mr. Secretary, I know you made reference to the problems that exist with the Section 202 elderly housing program. In fact, a director of a Area Agency in Maine brought to my attention the problems that he has been facing with a 20-unit program which they submitted to HUD for approval back in 1984 and, in fact, received it. It is 5 years later, and they have not received the funds.

Again, I think this points to a serious problem, as you mentioned in your testimony and others have made reference to here today. Frankly, problems like this are going to inhibit developers from becoming involved in these programs. As you mentioned, the number of units that are already in the pipeline and have not been approved are a serious problem.

Mr. **Kemp**. Right.

Ms. **Snowe**. As I was talking to this director the other day, he indicated he would never get involved in another one of these programs; it has just been a nightmare.

Mr. **Kemp**. I was looking back at my assistant secretary for legislative affairs, and I was going to suggest that Mr. Coyle call you this afternoon and get the name of that 202 project.

As I alluded to earlier, Olympia, there are over 30,000 units that have been clogged up in the pipeline, and I am committed, as I told the chairwoman and also Chairman Roybal, that I would personally direct HUD to do all that it could do immediately to expedite with dispatch this very important construction program for senior citizen housing.

So I would be happy to work not only with you, Olympia, but any member of the committee who has got a problem in his or her district. We will set up an immediate interface with this committee to work on those projects and get it unclogged.

I must admit, I haven't been there long enough to know why it got clogged up and why this problem existed, but I am committed to making it work in an expeditious fashion.

Ms. **Snowe**. I appreciate what you have to say. You obviously are facing a monumental task and challenge concerning a number of problems at HUD, and certainly this is one of them. It just points up to what might happen in the future. We may not be able to put some of these projects on line.

Interestingly enough, because of the delays, the State of Maine has not expended all of its money because they can't get approval. I just wanted to bring this program to your attention as an illustration of some of the problems you are already aware of. So I appreciate your support.

Mr. **Kemp**. Thank you.

Ms. **Snowe**. Maine has been a leader in congregate housing programs. We have 20 sites in addition to the three Federal sites. What can we do in the future—and this may be one way of approaching this problem and expanding supportive services—to help the States in undertaking their own initiatives in congregate housing programs? Perhaps we could set up a matching fund program as a way in which to encourage States to engage in or expand their already existing programs.

Mr. **Kemp**. I feel very strongly that what you have touched on is a very important need for all of us in Washington, in the Congress as well as in the administration, not only in the area of housing and congregate services and new ideas that both you and Ms. Oakar have mentioned, but I think we have got to be more cooperative with the States.

Some of the most interesting ideas are coming out of the States, and, as you pointed out, in Maine there has been a very positive approach to congregate services for the elderly and frail elderly in particular. I would like to see us be more cooperative with them. We met yesterday in our Low Income Opportunity Board in the Domestic Policy Committee, which I attended with other members of the Cabinet, and I think there is a real spirit in the administration of allowing not only in the field of welfare reform but in the area alluded to by the gentlelady from Maine that we need to allow the States to have more opportunity—flexibility, if you will—not laissez faire but an approach to working with them to allow these demonstration projects and paradigms to move forward that can be modeled or to be used by other States as well. So that is certainly going to be our attitude at HUD, and I think I can speak for the whole Bush administration in suggesting that the President wants to do this in a lot of different areas as well.

Ms. **Snowe**. Well, thank you again for being here today, and good luck.

Mr. **Kemp**. Thank you.

Ms. **Oakar**. Mr. Wyden.

Mr. **Wyden**. Thank you, Madam Chair.

Jack, that was a strong and positive statement, and we appreciate it.

Mr. **Kemp**. Thank you, Ron.

Mr. **Wyden**. You heard me in my opening statement express an interest in knowing, of that $2 billion that you said has been lost as a result of the problems of your predecessor, about how much has been attributable to programs affecting seniors?

Mr. **Kemp**. I had trouble, Ron, with this statistic because it didn't separate the problems of coinsurance which were more driven by the economy than by scandal, per se.

It would be very difficult, I would say to the gentleman from Oregon, to tie down specifically what was lost in the senior area. We estimated that coinsurance, which could run the gamut of the housing programs from the young to the old, would be in the range of $200 million or $250 million, but I don't think that was scandalous, per se, I think it is an unfortunate consequence of the very high interest rate policy of deflation through which we went in the 1980's and has manifested itself in certain parts of the oil patch more than others.

Mr. **Kemp**. So I want to be careful in answering your question more specifically today than perhaps I was with my friend, Charlie Schumer.

Mr. **Wyden**. Why don't we leave the record open on that point, Mr. Secretary, and if you could supply us with some information, but it was my understanding that it was a significant number of programs. You have said $200 million as it relates to coinsurance, which affects all population groups, and let's leave the record open, and that would be helpful.

Mr. **Kemp**. I will probably have to clear this up for the record. I don't mean to dodge. I don't think there is any member of the committee that thinks we are not going to let the chips fall where they may, but I will specifically answer in a letter to the gentleman and to the committee about how to distinguish between what has happened in different areas.

Mr. **Wyden**. That is helpful. You have talked about coinsurance. That affects all the population groups. And your statement that it might be in the ball park of $200 million is helpful today. We will leave the record open.

[The following material was subsequently received from Secretary Kemp:]

While much research has been and continues to be done to develop the specific numbers which you have requested, I am unable to give an exact accounting at this time. As I stated previously in testimony, it is particularly difficult to identify and separate elderly losses from the total universe of FHA losses or other costs attributable to past poor departmental management. One program which has been mentioned specifically in testimony is coinsurance which encompasses a wide range of housing initiatives including the Retirement Service Center program for the elderly.

However, the fact that total figures are not yet ready, defining exact losses in programs such as coinsurance, has not slowed our efforts to correct the problems facing the Department. I have taken steps to terminate the multifamily coinsurance program including the Retirement Service Centers because sufficient changes cannot be implemented to prevent the type abuses which the program experienced in the past. Coinsurance will be replaced with a modified and streamlined full insurance system.

Additionally, in October 1989, Congress passed and the President signed reform legislation for HUD. Included in this package were department-wide ethics and management reforms as well as changes to specific programs which required statutory change. Through these reforms this Administration has taken direct action to see that past abuses and weaknesses in the system do not continue to be a problem at HUD.

Mr. **Wyden**. Mr. Secretary, do you expect to put together a written strategy to prevent the unnecessary institutionalization of the elderly? The reason I ask is that this Memo of Understanding, we appreciate your comments on that. We have been trying to get that for about 5 or 6 years. That has been a long-standing matter. Do you expect to put together a written strategy to prevent unnecessary institutionalization of the elderly?

Mr. **Kemp**. Yes.

Mr. **Wyden**. If so, when do you think we might get it?

Mr. **Kemp**. I would say to the gentleman from Oregon, we will submit to him and the committee just as soon as possible that memorandum of understanding, and I know he doesn't blame me for the last 5 years, but I certainly feel responsible for doing it with dispatch, and I will work very closely with him and rest of the committee to make sure that it is done expeditiously and make that pledge here today.

I would rather not be making a date certain, but I'm not interested, as the gentleman knows, in dragging these things out. I just pledge to work with you and to get it to you as soon as I possibly can.

[The following material was subsequently received from Secretary Kemp:]

HUD has taken several steps to address the needs of the frail elderly in this country. In the past there have been problems in the linkage between HUD, HHS and other agencies providing services which prevented optimum use of funds and efforts for the elderly. In an effort to co-ordinate programs in the various agencies Secretary Sullivan and I signed a memorandum of understanding on January 24, 1990, in which we agreed to work together to assure that HHS services were more effectively directed to HUD support recipients.

In further efforts to co-ordinate assistance, the Housing office is working with Public Housing and Indian Programs and the Administration of Aging (AoA) to establish goals for the frail elderly and non-elderly handicapped populations. An interagency agreement with AoA is in clearance. This agreement will jointly do the following:

1. Require our field offices and AoA-sponsored Aging network staff to work together to develop state and local level coordination agreements to ensure that a higher level of available resources is targeted to those frail elderly in assisted housing.
2. Provide training and technical assistance to HUD staff and HUD project managers.

3. Develop a handbook of supportive services and services management for the 1990s, and a directory of HUD housing for the elderly and the handicapped.

4. Develop a policy defining "frail elderly" for HUD, and regarding service coordinators in HUD projects.

5. Hold a series of national and regional conferences on aging in place and the frail elderly in HUD projects.

6. Determine retrofitting needs and costs for HUD projects in the 1990's to meet the needs of the frail elderly.

7. Begin working with the National Institute of Mental Health (NIMH) and other agencies to expand these activities to address the needs of the chronically mentally ill population in projects for the elderly.

In addition to the initiatives with HHS, President Bush and I have submitted the Elderly Independence Demonstration Program as part of the Administration's **Homeownership and Opportunity for People Everywhere (HOPE)** proposals. This demonstration builds on the "Supportive Services for the Frail Elderly" Report which I sent to Congress in October 1989.

Under the HOPE demonstration proposals for FY 1991, the housing vouchers for the elderly would be enhanced so that PHAs could combine both rental assistance and a services co-payment.

This enhanced voucher would not be project based, as in the past, thereby targeting frail elderly in the general community. This would allow them to remain in their current apartment as long as it meets the Section 8 Housing Quality Standards. This program would further reduce the impact on elderly Americans needing assistance but not wishing to leave the familiar surroundings of their home.

U.S. Department of Housing and Urban Development
Office of Public Affairs

Washington, D.C. 20410

News Release

HUD No. 90-13
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FOR RELEASE:
Wednesday,
January 24, 1990

KEMP, SULLIVAN COMMIT TO COORDINATE HOUSING, WELFARE PROGRAMS

Secretary of Housing and Urban Development Jack Kemp, and the Secretary of Health and Human Services, Louis W. Sullivan, M.D., today signed a Memorandum of Understanding with the ultimate goal of more effectively helping poor families and individuals move toward independent living and economic independence.

Secretaries Kemp and Sullivan pledged to jointly develop and implement initiatives for "Partnerships in Self-Reliance." Initially, the cooperative inter-agency effort will focus its efforts on homeless families with children, welfare families in public and assisted housing, and seriously mentally ill homeless individuals.

In the Memorandum of Understanding, the Cabinet Secretaries of the Federal government's two major anti-poverty agencies noted that 1990 marks the 26th anniversary of the passage of the Economic Opportunity Act, the country's original declaration of war on poverty. They agreed that it was time for the nation--which is experiencing a period of sustained prosperity--to renew its commitment to help those still in the grip of poverty.

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"Over the last twenty-five years, anti-poverty programs have been more successful in alleviating some of the worst symptoms of poverty than in reducing its incidence," Kemp and Sullivan said. "The new phase of this war must have as its goal the economic empowerment of our disenfranchised citizens and communities.

"This Memorandum of Understanding is a small first step to mark our long-term commitment to pursuing solutions jointly with the considerable resources at the disposal of the Departments of HHS and HUD. Small steps steadily taken will lead unfailingly toward solid progress."

Both Cabinet departments administer a wide variety of programs that provide assistance to low-income and homeless families and individuals. Both Departments, under their new Secretaries, are implementing new approaches to aiding the poor.

The long-term goal of today's agreement is to coordinate programs and initiatives at the Federal level, as well as between the Federal, state, and local governments and private philanthropic groups. Under the Memorandum of Understanding, HUD and HHS will jointly undertake policy reviews, pilot projects, and conduct research and evaluation.

The Secretaries of HHS and HUD will establish the necessary administrative structure to implement the Memorandum, including appointment of senior persons to oversee its implementation, and forming working groups to develop specific activities, budget proposals, and schedules.

# # #

MEMORANDUM OF UNDERSTANDING

This year marks the twenty-sixth anniversary of the passage of the Economic Opportunity Act, the country's declaration of war on poverty. It is high time that the nation make a renewed commitment to revitalizing its anti-poverty efforts. Even as the country as a whole experiences a sustained period of economic progress and prosperity, too many of our citizens seem mired in the grip of intractable poverty. Over the last twenty-five years, anti-poverty programs have been more successful in alleviating some of the worst symptoms of poverty than in reducing its incidence. The new phase of this war must thus have as its goal the economic empowerment of our disenfranchised citizens and communities.

The purpose of this Memorandum of Understanding (MOU) is to establish the framework for a continuing relationship between the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) to jointly develop and implement initiatives for "Partnerships in Self-Reliance", a cooperative inter-agency effort to help homeless and low-income families and individuals move toward independent living and economic independence.

This MOU is but a small first step to mark our long-term commitment to pursuing solutions jointly with the considerable resources at the disposal of the Departments of HHS and HUD. Small steps steadily taken will lead unfailingly toward solid progress.

Background

HHS and HUD administer a wide variety of programs that provide assistance to low-income and homeless families and individuals. Both Departments are implementing new approaches to help families and individuals served by social welfare and housing programs.

Each Department, however, administers its programs separately under specific statutory authorities, regulations and procedures. Moreover, these programs are implemented by a multiplicity of diverse State and local agencies, and often at different levels of government. Thus, even though their clientele may be the same, there are no systematic mechanisms at the Federal, State or community level to coordinate and integrate housing, health, support service and income assistance programs.

We, the undersigned Secretaries of HHS and HUD, recognize that cooperative initiatives between HHS and HUD can better achieve the Administration's goals to empower the poor to control their lives, of assisting the poor to climb ladders of opportunity, and of ending the tragedy of homelessness.

The Initiative

HHS and HUD will undertake a series of joint activities to focus the resources of the two Departments effectively. Because of the urgency of their needs, the first joint efforts will focus on three of the most vulnerable groups among the poor:

- welfare families in public and assisted housing;
- homeless families with children; and
- the seriously mentally ill homeless.

The purpose of the activities will be:

- to provide low-income families and individuals with ladders of opportunities for employment, self-sufficiency and homeownership; and
- to reduce the numbers of homeless in the streets and emergency shelters by strengthening and improving the safety net of needs-based housing and human services assistance.

Federal funds will be used to promote cooperation and coordination among State and local housing, health, income assistance, and human services providers and administrators, and non-profits and community organizations. Our envisioned goal is to encourage the development of systems that integrate housing, income assistance, health, and other support services.

Three principal types of activities will be undertaken for each group:

- Pilot projects in communities. In the near term, within existing statutory and program constraints, HUD and HHS will coordinate their administration of programs at the Federal level to promote more integrated use of their resources in projects at the community level, with the goal of providing multiple services to persons with multiple needs in a holistic approach. In the longer term, the working groups established by this MOU will develop joint proposals to integrate human services and housing assistance to promote self-sufficiency.
- Policy review and development. HHS and HUD will jointly develop policy objectives with regard to each target population and review HHS and HUD statutory and regulatory requirements to identify areas where current requirements do not fully support these objectives. HHS and HUD will make or propose changes to these requirements necessary to make our programs work together more effectively.

- Research and evaluation. HHS and HUD will develop and carry out a joint research and evaluation agenda in order to expand knowledge of the families and individuals we are seeking to help, and the approaches which are likely to meet established policy objectives. They will develop mechanisms to share information with each Department's grantees, disseminate best practices, test innovative program concepts and techniques and evaluate jointly funded activities.

The Secretaries of HHS and HUD will establish the necessary administrative structure to implement this memorandum, including appointment of senior persons to oversee implementation, designation of individuals to serve on working groups to develop and implement specific activities and budget proposals and implementation schedules.

DATE: 1-24-90

Louis W. Sullivan, MD
Louis W. Sullivan, M. D.
Secretary

Department of Health and
Human Services

Jack Kemp
Jack Kemp
Secretary

Department of Housing and
Urban Development

Mr. **Wyden**. Could I ask one other question?

Ms. **Oakar**. Can I just say that I'm going to ask unanimous consent, Ron, with everyone's agreement, that we now limit—since has to leave and we want him to come back to the Aging Committee, if we could just have every single Member ask the Secretary one question, so that everybody gets a chance, if you don't mind, Ron.

Mr. **Wyden**. No.

Ms. **Oakar**. Every Member can submit to the Secretary questions in writing for the record.

With that, why don't you ask your question, but maybe we will let the Secretary answer it in writing, but get it on the record.

Mr. **Wyden**. No. I'd be happy to defer to my colleagues.

Ms. **Oakar**. All right. So I am going to ask unanimous consent that each Member have one question.

Mr. James.

Mr. **James**. Thank you.

What movement are you making on the tax credit or the depreciation for housing for the poor and the elderly? Sometimes they are the same, sometimes they are not, but they are inter-related problems, the way I see it. In other words, do you have a proposed bill? Do you have studies that will show any specific recommendations for tax credits or for reinstitution of depreciation where there is not sufficient income, how it will affect the economy? In other words, how far are you along in that analysis, and do you have a proposed bill?

Mr. **Kemp**. Yes. I supported the Rangel bill for LITC—low-income housing tax credit. My understanding is that that was passed by the Ways and Means Committee with the support of the Bush administration and a broad range of bipartisan support.

I was particularly pleased that Chairman Rangel included incentivizing the nonprofits. I don't want to sound, as a great believer in the profit system, that I am losing faith in it at all, but I have seen the work being done by the nonprofits, and I was pleased that the LITC was being used not only to incentivize investment in low-income housing for people but also the nonprofits as well.

Ms. **Oakar**. Thank you, Mr. Secretary.

Mr. Kennedy.

Mr. **Kennedy**. Thank you, Madam Chairwoman.

Jack, I want to just pursue a quick line of questioning with you. I appreciate your comments, and I'd like to get some further information on the 221(d)(4) program. I don't want to pursue that right at this moment, however. I am more interested in your general notion that the elderly should stay in their existing housing.

You are very familiar with the fact that around our country we have very different housing problems, but up in the part of the country that a lot of us come from, in New England and, really, along the East Coast and the more crowded parts of our country, there are a lot of senior citizens that are living in homes that they have perhaps purchased along with their spouses 30 or 40 years ago. They live in those homes now, their children have moved out, and essentially they are over-housed. At the same time, many young families can't get access to existing housing.

I wonder what your thoughts are on how we can use existing housing stock much more efficiently and effectively and still meet our elderly citizens' needs. It seems that there is a lot of room in there to be able to come up with some innovative programs that don't necessarily cost the Government a heck of a lot of money and yet are able to catch some of those inequalities in the system.

Mr. **Kemp**. Mr. Pallone mentioned the home equity conversion mortgage, the reverse mortgage idea. I think that is an innovative idea and one that should be expanded. I think there is a bill in to expand it. I think it should be expanded.

I think the gentleman from Massachusetts, with whom we have met on a couple of occasions on this issue, has come up with one of the real dilemmas of our society in which people become locked into that home and have all of their equity in that capital investment that they made a long time ago, and a lock on that investment precludes not only them from doing something different when they are senior in their retiring years, but it also inhibits the availability of that stock to other folks.

Continually there has been in America a chance for people to move up and through housing as well as in other areas of the economy, and, having said that, I, for a long time—and here I go again on tax policy, but I wouldn't be surprised if the treatment of your home by capital gains ought to be reconsidered. A lot of people who are forced always to move into a higher cost home—that that isn't having an impact upon both the availability as well as the opportunity for people to do things.

So it may be that we ought to look, and I am just saying this now in this arena as a possible idea that the capital gain on a principal home might be changed considerably. We might negate the capital gain on your principal home rather than always say it has to be rolled over into a higher priced home.

I think the gentleman from Massachusetts, however, has come up with a key issue. I would be glad to work with him. I don't have any innovative, bold, dramatic, audacious, new ideas to come up with, but I have a staff and the attitude that we want to.

Mr. **Kennedy**. I think there are a whole range—

Mr. **Kemp**. I agree.

Mr. **Kennedy**. Just to finish the comment, there are a whole range of initiatives that I think even this committee could investigate with you at some point in the future. I would look forward to it. Thank you, Mr. Secretary.

Ms. **Oakar**. Mrs. Bentley.

Mrs. **Bentley**. Thank you, Madam Chairman.

Mr. Secretary, welcome.

Mr. **Kemp**. Thank you.

Mrs. **Bentley**. And may I say, while you are playing around with changing the capital gains structure on investments in homes, consider changing the taxing, the property taxing, for those who maintain their homes and keep putting money back in to maintain the property. Rather than their having to pay higher taxes while the other ones who don't do it pay less—

Mr. **Kemp**. Hear, hear.

Mrs. **Bentley**. I mean that is one of the complaints that I hear from my seniors all the time.

Mr. **Kemp**. I applaud your idea. I applaud it.

Mrs. **Bentley**. I will send you some questions. I just want to say I think you are very definitely on the right track of trying to work out a program for seniors to stay in their homes as long as they are able to do anything at all for themselves. I applaud that, and I would like to work with you on it.

Mr. **Kemp**. Thank you. Thank you, Helen.

Ms. **Oakar**. Thank you.

Mr. Pallone.

Mr. **Pallone**. Mr. Secretary, you answered my question about the home equity conversion. You indicated that you would support the expansion. I appreciate that. So I am going to ask another question.

You mentioned in your statement abut the CHSP program and the tighter eligibility requirements, that originally an elderly person had to demonstrate that he needed assistance in one activity of daily living and now it has been expanded or, I guess, contracted, if you will, to three or more of these activities.

Would you support going back to the original one, or is that just a question of finances? Because I know that that is another major problem in that now the eligibility is so much tighter because you have to show disability or needs, if you will, in greater areas. Is that something that you are moving on or that you would support, going back to just one criterion as opposed to the three or four that are now required?

Mr. **Kemp**. I would want to look at that option and not put myself in concrete at this time. My support for CHSP, the Congregate Housing Service Program, is strong, but I would like, as I review all of these programs, to do it with an open eye and an open mind and certainly an open heart as well. I think we have to be careful, though.

This whole question that I have been talking about in areas from the Senior Service Retirement Center to Mod/Rehab to CDBG is need. I want HUD and I want us to focus in on the needy, and one of the problems we have gotten into—and I am not now taking your question away from your premise, but I think it is very important that we at HUD make sure that the programs are carefully targeted, and I have said many times I don't want CDBG to be building swimming pools, I don't want retirement centers to be going to wealthy centers. Just so long as we keep need at the forefront as our guiding principle, I would be happy to look at any idea with regard to making that program work better.

Mr. **Pallone**. Thank you. I just mention that because I know that in many cases we do have some good programs, but because of the tightness of eligibility a lot of people don't take benefits. It is something that we need to look at.

Thank you.

Thank you, Madam Chairwoman.

Ms. **Oakar**. We are going to keep you 3 more minutes Jack.

Mrs. Morella.

Mrs. **Morella**. Madam Chair, I want to ask unanimous consent that my opening statement be included in the record.

Ms. **Oakar**. Without objection, it is so ordered.

[The prepared statement of Representative Morella follows:]

HON. CONSTANCE MORELLA
SELECT COMMITTEE ON AGING
JULY 26, 1989

Constance A. Morella

MR. CHAIRMAN, THANK YOU FOR SCHEDULING THIS SECOND HEARING ON THE NEEDS OF THE FRAIL ELDERLY IN FEDERAL SUBSIDIZED HOUSING. I AM PARTICULARLY PLEASED THAT HUD SECRETARY JACK KEMP IS ABLE TO JOIN US TODAY. I KNOW THAT SECRETARY KEMP IS VERY INTERESTED IN THIS ISSUE, AND I LOOK FORWARD TO HEARING HIS IDEAS AND GOALS TO MEET THE NEEDS OF THIS VULNERABLE GROUP. I SUPPORT THE SECRETARY IN HIS TASK OF CLEANING UP HUD'S FEDERAL HOUSING PROGRAMS.

HOUSING IS AN INTEGRAL PART OF OVERALL CARE FOR THE ELDERLY. WITH THE AGING OF OUR POPULATION, THIS ISSUE WILL BECOME INCREASINGLY CRITICAL. PREVIOUS HEARINGS OF THIS COMMITTEE HAVE INDICATED THAT THIRTY PERCENT OF THE ELDERLY LIVE IN DETERIORATING OR DILAPIDATED HOUSING, AND THAT PEOPLE OVER THE AGE OF 75 PAY 48% OF THEIR INCOME FOR HOUSING. IN THE EIGHTH CONGRESSIONAL DISTRICT OF MARYLAND, THE MONTGOMERY COUNTY DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT USES PRIVATE FUNDS AND LOCAL, STATE AND FEDERAL GOVERNMENT FUNDS TO MEET THE ELDER HOUSING NEEDS OF THE COUNTY. MONTGOMERY COUNTY NEEDS AT LEAST 12,000 UNITS OF ELDER HOUSING, AND IN 1988, THE COUNTY ADDED APPROXIMATELY 600 UNITS. CLEARLY, THE NEED FOR ELDER HOUSING IS GREAT.

ADEQUATE SUPPORT SERVICES ARE ALSO NEEDED TO ASSIST MANY OF THE FRAIL ELDERLY IN THEIR APARTMENTS, AND IMPROVED COORDINATION BETWEEN EXISTING LONG-TERM CARE SERVICES AND CONGREGATE HOUSING PROGRAMS IS VITAL TO THE WELL-BEING OF THIS POPULATION. I APPRECIATE YOUR EFFORTS IN THIS REGARD, MR. CHAIRMAN, AND I HOPE TODAY'S HEARING WILL HELP TO UNIFY THE WORK OF CONGRESS AND THE ADMINISTRATION TOWARD MEETING THE HOUSING AND HEALTH NEEDS OF THE FRAIL ELDERLY.

FINALLY, IN THE WORDS OF HUBERT H. HUMPHREY: "...THE MORAL TEST OF GOVERNMENT IS HOW THAT GOVERNMENT TREATS THOSE WHO ARE IN THE DAWN OF LIFE, THE CHILDREN; THOSE WHO ARE IN THE TWILIGHT OF LIFE, THE ELDERLY; AND THOSE WHO ARE IN THE SHADOWS OF LIFE--THE SICK, THE NEEDY AND THE HANDICAPPED." I LOOK FORWARD TO HEARING FROM SECRETARY KEMP TODAY AND TO WORKING WITH HIM IN THIS CONGRESS TO PROVIDE HOUSING TO THOSE PEOPLE MOST IN NEED.

Mrs. **Morella**. Thank you, and I want to congratulate our Secretary for the energy and commitment that he places in what he is doing.

My question is a very brief one. I am wondering, Mr. Secretary, what HUD is planning to do with the Section 8 contracts that are expiring, something my community has been very interested in.

Mr. **Kemp**. While you were asking me the question, I did something unforgivable, Connie. I was looking for a note that I had written myself on an answer to a previous question on which I have made a mistake and I wanted to clear up, Madam Chairman, before I left.

Ms. **Oakar**. Without objection.

Mr. **Kemp**. So I apologize to the gentlelady from Maryland.

Could I, for the record, tell my friends on the committee that I had made a mistake when I suggested that the coinsurance was $200 million. I should have said the retirement service center default was $200 million. It was about 30 percent of all of the existing contracts.

So if you want a figure as to what part of the $2 billion was senior related, it would be 30 percent of that program, but I wanted to reassure the committee, Connie, and I hope your time is not diminished, and I will certainly stay longer to avail myself of the opportunity to answer your question. But it was a default rate of 30 percent. There is about $200 million in that program, but, as I told Joe Kennedy, we are going to tighten it up and target it better and get it reopened.

Ms. **Oakar**. Mr. Wyden, since you asked the question, we will give you the time.

Mrs. **Morella**. I would yield to the gentleman.

Mr. **Wyden**. Just for 5 seconds, Connie. I will be real brief.

Mr. Secretary, I very much appreciate your focusing on that as the default rate, because that is what we are concerned with, and that will be the $200 million.

Let us still leave the record open so that you can really go into it in detail.

Mr. **Kemp**. I will be happy to.

Mr. **Wyden**. I thank the gentlelady.

Mr. **Kemp**. I will be happy to, and I didn't want anybody to think that I wanted to leave that question open. But we will be glad to respond more directly. Now could I say to Connie Morella, my Congresswoman, would you repeat the question?

Mrs. **Morella**. Certainly. You didn't expect there to be such a brief, succinct question. What is HUD planning to do with the Section 8 contracts that are expiring?

Mr. **Kemp**. Well, let me say to you directly and to the committee, we are committed in the Bush administration to 100 percent cooperation in making sure that the expiring contracts and the responsibility that we have is fully met, and the cost may be somewhat more than was originally estimated in the budget authority, but we are committed to 100 percent cooperating with the Congress and finding the solution, with a variety of tools, to this problem of Section 8 expirations, the contract expiration.

Ms. **Oakar**. We are pleased to have Mr. Kemp here.

Connie, did you—

Mrs. **MORELLA**. Well, no. I can follow through specifically with the staff, if that is okay.

Ms. **OAKAR**. We want to acknowledge Mr. Bilbray and Mrs. Unsoeld. Do you have a question? The Secretary is under a time constraint.

Mr. **BILBRAY**. I had some questions, but I would like to submit them in writing to the Secretary's office.

Ms. **OAKAR**. Without objection, it is so ordered.

Mr. **BILBRAY**. Thank you.

Mr. **KEMP**. Thank you.

Ms. **OAKAR**. Mr. Secretary, Mr. Wyden has one last question.

Mr. **WYDEN**. Only if my colleague will allow.

Mrs. **UNSOELD**. Go ahead.

Mr. **WYDEN**. Mr. Secretary, your proposal with respect to drug dealers in public housing, it seems to me, is a very good one. What is the effect going to be on seniors, though, because you, like us, we don't want to see innocent senior citizens hurt because we are trying to kick the drug dealers out. How would that work?

Mr. **KEMP**. Well, let me just briefly say that I don't think you can make a distinction on this issue by age. When I first started, I thought this was just a male dominated problem; it is not; it is female/male. You cannot pick the color. There are many, many wonderful people living in public housing, in HUD-assisted housing, and I have visited both the public housing as well as the HUD-assisted housing projects in communities around the country and right here in the District of Columbia, and I have seen paradigms of virtue, and I have seen models of failure.

I have no specific response in terms of just senior citizens. I would say that there has been some misperception that somehow Kemp, or Bennett, or Bush, or the administration, or HUD wanted to affect the whole family; we do not. I said openly and many times in answer to Chairman Rangel, who is probably as on top of this issue as anybody else, that we wanted to take it on a case-by-case basis, and where a family was not involved with the problems of a teenage son who is 6 foot 4 and 240 pounds and would whip up on any mom or dad who tried to get them, then they should not be punished. But where, bizarre as it sounds, the family was involved, as in the case out here in Washington, D.C., of a public housing family that had been evicted, frankly, they should have been evicted. There is public housing for people who traffic in drugs, and it is called a jail.

But we are going to be very careful about due process. We are going to be tough on drugs, but I would say to the gentleman from Oregon and other members of the committee there is a comma after that statement—I want to be tough for due process. We have not relaxed the effort to give people a hearing, all we have done is say where HUD was interfering in the policy of evicting a person, or a couple, or a family, if that were the bizarre case, then we didn't want HUD to put a year of a lease and grievance hearing in between that and the court. But these cases are going to court, and we will only waive HUD's procedure where there is due process that we can be assured through our general counsel is available.

Thank you.

Mr. **Wyden**. I support your proposal, and thanks for your answer.

Mr. **Kemp**. Thank you.

Mr. **Bilbray**. I just want to make one statement, no question.

Ms. **Oakar**. Mr. Bilbray.

Mr. **Bilbray**. Mr. Secretary, as one Member of Congress, we didn't get to know each other much when we served, we only served one term together, but I have been watching your performance, and I am extremely pleased with how you have been handling that Department.

Mr. **Kemp**. Thank you.

Mr. **Bilbray**. If all Secretaries conducted their business like you, I think we would have a much better Government.

Mr. **Kemp**. I am flattered. Thank you very much.

Ms. **Oakar**. Mr. Secretary, thank you very much, and you know that crime is the number one issue for people, for elderly in particular, who live in public housing.

Mr. **Kemp**. They are being victimized; you are right, Madam Chair.

Ms. **Oakar**. So you are right on target with what you are doing with those drug dealers.

Mr. **Kemp**. I apologize for having to leave. I have got all the State Housing Authorities from all over the country here, and I know many of your States will be represented, and I want to go meet with them. So I thank the committee.

Ms. **Oakar**. They are indeed, and thank you for coming. Come back often to the Aging Committee.

We are delighted to have someone who has consented to appear before the committee relative to the question of services and the needs of frail elderly. Probably the best witness we could have is an older American himself.

Mr. Edwin Kent of Arlington, Virginia, please come forward, and I am going to turn the chair over to Mr. Wyden.

Mr. **Wyden** (presiding). We welcome you all very, very much. We will make your prepared remarks a part of the record completely, and if you would like to perhaps just summarize in a few minutes some of the key concerns that you all have, I share the views of our chair, how important you all are and look forward to your views.

STATEMENT OF PAT WADDY, PROPERTY MANAGER, CAFRITZ COMPANY

Ms. **Waddy**. Thank you very much. Good morning. My name is Pat Waddy, and I'm the property manager for the Cafritz Company, and I have over 600 units of Section 8 elderly, one in Arlington and one in Alexandria, and Mr. Kent participates in the support systems of the Arlington Claridge House 1, and they have asked him to tell some of the things that he is able to do because of this.

So if there are any questions for me, it is no problem, but actually this is Mr. Edwin Kent.

STATEMENT OF EDWIN KENT, SENIOR CITIZEN, ARLINGTON, VIRGINIA

Mr. **Kent**. Good morning, Mr. Chairman and members of the Committee on Aging. Thank you for giving me the great honor to come before you to express my views on the need for linking housing and services.

My name is Edwin Kent, and I live at Claridge House 1 in Arlington. I am 69 years old. Here are some of the services that Arlington County provides to help me maintain my independence: evening meals from Monday through Friday; I have home service laundry and bed making, a lady to help me; I have a hotline for help; if I need any kind of help next day, I just call and the lady is there; we have beautiful transportation; a Red Cross bus comes by every week and takes us food shopping, and then, luckily, there is a Crystal City trolley that takes us up to the Crystal Plaza if we need any extra food. Also, FISH is a coalition of business organizations that helps with things like transportation. FISH stands for "Families In Need of Sympathetic Help."

After that brief lesson, I think the best procedure would be to open the discussion to questions. I'd be happy to answer any questions I can.

Mr. **Wyden**. Thank you very much.

I had more than my share of questions the last time. Let me go to my colleagues for any that they would like to ask, Mr. Bilbray and Mrs. Unsoeld.

Congresswoman Unsoeld.

Mrs. **Unsoeld**. Would you suggest any changes to those programs that you described or adding any to meet some of your needs that perhaps are not currently being met?

Mr. **Kent**. Ma'am, I am very sorry to tell you that I can hear but I cannot understand.

Mrs. **Unsoeld**. Okay.

Ms. **Waddy**. She wants to know if there are other needs that need to be met that are not met by the program.

Mr. **Kent**. I can't think of any offhand. We are very fortunate.

Mrs. **Unsoeld**. I'm pleased. Thank you.

Mr. **Wyden**. Mr. James.

Mr. **James**. I have no questions, but I will probably see you shopping in that same shopping center; that is where I do some of my shopping; I live in Crystal City, too.

Ms. **Waddy**. He says he lives in Crystal City, and maybe he sees you in that same shopping center.

Mr. **James**. I will probably see you there.

Mr. **Wyden**. Congresswoman Morella.

Mrs. **Morella**. Mr. Kent, I just want to thank you for appearing before us today. Your testimony and your commitment mean a great deal to us. I think your presence and what you have said say it all. It is a nice finale to our hearing. Thank you.

Mr. **Wyden**. I have just one question. Mr. Kent, without these services—and I recognize the difficulty in getting them—it would be hard to be independent and be in the community.

Ms. **Waddy**. He said that without these services, would you be able to be independent in the community?

Mr. **Kent**. Yes. Yes.

Ms. **Waddy**. He is saying without the services, Mr. Kent. He wants to know if you need the services to remain independent and live in the building.

Mr. **Kent**. Well, it helps. It helps to have them, but, if you don't mind, I could do it myself.

Mr. **Wyden**. You look like a real fighter.

Ms. **Waddy**. Very stubborn.

Mr. **Wyden**. And that is what it is all about, and you have been a very, very helpful witness, and we thank both of you for coming up. My colleagues may want to ask some more questions that they would send over in writing. We sure appreciate you all coming.

Unless there is anything further that the Members would like to add, I know we have a real bipartisan interest in working on these kinds of things, and the Committee on Aging will pursue them in the future. So the committee is adjourned.

[Whereupon, at 11:10 a.m., the hearing was adjourned.]

APPENDIX

NAHRO National Association of Housing and Redevelopment Officials
1320 Eighteenth Street, Northwest, Washington, D.C. 20036-1803 (202) 429-2960
Fax (202) 429-9684

May 31, 1989

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
U.S. House of Representatives
300 New Jersey Avenue, SE, Room 712
Washington, DC 20515

Dear Mr. Chairman:

The National Association of Housing and Redevelopment Officials (NAHRO) strongly supports the provisions in Section 4 of your bill, the Frail Elderly Act, (HR. 2376) introduced by you on May 22. We particularly support Section 4(a) that authorizes HUD operating assistance in public housing to support a position of "Services Coordinator" as well as a 15 percent contribution toward the provision of support services to assist elderly or handicapped public housing residents in maintaining independent living, preventing placement in nursing homes. As this legislation moves through the legislative process, we would recommend clarifying language that such assistance is separate from, and in addition to, the HUD Performance Funding System (PFS), which determines public housing operating subsidy on an annual basis.

We also support a provision (Section 5) that authorizes a centralized waiting list to be maintained by the public housing agency for all elderly or handicapped housing programs in a local community. However, we believe that it should be a single list, rather than a separate list for each program.

NAHRO is a 56-year old association representing the local administrators of public housing, neighborhood rehabilitation, community development and redevelopment programs. The Association was an initiator and strong supporter of the Congregate Housing Services Program (CHSP), enacted in 1978, under which 31 public housing agencies and 30 Section 202 non-profit housing sponsors have served over 2,200 frail elderly and handicapped persons. CHSP is an outstanding success.

Helen L. Sause, President, **Apolonio Flores**, Senior Vice President, **Michael A. Garcia, Jr.**, Vice President-Commissioners, **William H. Garrett**, Vice President-Community Revitalization and Development, **Jack Quinn**, Vice President-Housing, **Michael F. Hanratty**, Vice President-Member Services, **Ophelia B. Basgal**, Vice President-Professional Development, **Richard Y. Nelson, Jr.**, Executive Director

Recent information has documented that there are 1.52 million elderly households (over 65 years of age) in federally-assisted housing, with over 600,000 of these in public housing. A significant percentage of these persons have some frailty (e.g. inability to perform tasks of daily living), and are at risk of institutionalization. There is an urgent need to expand support services for these households to enable them to remain independent.

Mr. Chairman, we commend you for the inclusion of these provisions in HR. 2876.

Sincerely,

Richard Y. Nelson, Jr.
Executive Director

THE ELDERLY IN PUBLIC AND SUBSIDIZED HOUSING:

Meeting the Challenge of housing the frail elderly

by

Viola A. Brown-Kribich

ELDERLY POPULATION IN PUBLIC AND SUBSIDIZED HOUSING

MEETING THE CHALLENGE OF HOUSING THE FRAIL ELDERLY

When the nation's first housing act was passed in 1937, little, if any, thought was given to the question of providing housing for the elderly. In those times, the "elderly" were your parents or grandparents, and should they live to a ripe old age, there was no question that they would be living with some relative or spend their last years in the family homestead.

Society underwent massive upheavals with the onset of World War II, the post-war years, the "baby boom" and the continuing economic and social ferment which began in the fifties and affects American life today. Along with these changes, modifications occurred in the housing programs and their original intentions. Where few elderly units were formerly anticipated, more needed to be built to respond to a growing demand among seniors for housing, due in no small part to the changing structure of the American family, which no longer encompassed the "extended family", and most significantly, to the changing role of post-World War II women, who could no longer be counted on to automatically perform the role of nurse and caregiver.

Public housing (along with other state and locally-funded subsidized housing) responded to the need for increased senior housing. With the advent of Federal programs specifically designed for building senior housing (Section 202), and with congressmen working diligently to assure a fair share of housing funds for their districts, many units of elderly housing were constructed from the 1950s on. Additionally, and perhaps even more importantly in some communities, there was less opposition to the building of elderly housing than that of family housing. However, in building elderly housing, no forecasting was done of future events that might impact on what many housing providers have always considered the least worrisome, least financially taxing, and least problematic of their housing units.

Several providers of public and subsidized housing are now being confronted with the phenomenon of their elderly population "aging-in-place". The "aging-in-place" simply means that housing which was originally designed for the well elderly must now support a population that is increasingly frail due to advanced age. Nowhere is this aging-in-place more readily seen than in New York state, where subsidized housing has been provided for over fifty years through various agencies and programs. Additionally, the issue of aging-in-place is further exacerbated by several other dynamics impacting on the elderly housing market: a surfeit of available elderly housing, or housing which lends itself to elderly housing needs, a change in the demographics of the elderly population, and the desires of the elderly themselves. The purpose of this article is to describe the elderly housing situation in one urban area of New York (Rochester), which may have particular similarities to problems faced by other urban housing providers, and then to describe ways in which the local PHA is addressing the issues of aging-in-place and the growing number of elderly vacancies.

WHO ARE THE PEOPLE?

Today, at least one in every five Americans is at least 55 years old. At least one in eight is over 65. According to the Center for Governmental Research (a local public policy research organization in Rochester, New York) in a study prepared for the Rochester Housing Authority, by 1990, over one-third of the population of Monroe County (which contains the city of Rochester) would be elderly (over 62). The elderly population from which current and future public housing residents will be drawn is increasingly poorer and more frail than in past years. Comprative data developed by the Authority shows that in 1970 fully 90% of those admitted to elderly housing were underseventy years of age. By 1987, however, those numbers had shifted with over 75% of the Authority's new admissions coming from ages seventy and over.

Better health care coupled with changes in occupations have contributed significantly to a rise in life expectancy for all Americans. The generation now being called "mature adults" or "senior citizens" is the first in which this extended life span is most obvious, at least to the "baby boomers" whose present earnings are tapped to provide for today's elderly. Because people are living longer, housing which was supposed to be at best temporary has had to adapt. Housing and planning information and projections made in the 1950s - 60s indicate that many planners estimated the average length of tenancy for an elderly resident to be no more than five to ten years, after which the resident would either die or move into a higher level of care, primarily a nursing home. Social scientists of that era could not, or did not, accurately predict the upheavals which have occurred in American life within the last ten to twenty years: a lessening of dependence on the nuclear family for support of elderly family members; increasing numbers of females who are widowed, divorced, or never married (and who, by the way constitute the greatest number of the elderly poor); the disinclination of states to continue to shelter "at-risk" populations, based largely on court decisions that have led to what is euphemistically called "de-institutionalization"; economic currents which have significantly altered or permanently disrupted the cycling and recycling of housing, and that has contributed to the greatest incidence of homelessness in American society since the Great Depression.

Anyone doubting that there is numerically a growing elderly population need only look at the number of organizations that have developed relatively recently to advocate for or to service the elderly: perhaps the best known are the American Association of Retired Persons, the National Council on Aging, the "Gray Panthers", and several other smaller, more targeted (in terms of interest group) agencies and organizations."Old age" as a simplistic definition of what happens after retirement no longer exists. It is now divided and sub-divided into several categories: the "near-elderly"; the "young elderly"; the "well elderly"; the "frail elderly"; the "advanced elderly", not to mention the various economic, ethnic, and class categories that may be applied. Attempting to provide housing across all these subgroups becomes an almost impossible task for public and subsidized housing providers, who cannot compete against the private market for various reasons which will be developed further in the text.

What providers of public and subsidized housing have had, however, is an increase in the number of applicants and tenants from populations with few other options in housing. Data obtained from records on new admissions to the Rochester Housing Authority indicate a growing trend toward new tenants who are older, less mobile, and less healthy than the elderly population in general. Additionally, under Federal regulations, disabled persons are also defined as elderly, and the disabilities being claimed by many new admissions are not only physical disabilities, but also disabilities related to substance abuse, mental or psychological disorders or impairments, or other socialization disorders.

The Housing

Most housing built with Federal or state subsidy for the elderly (or, for that matter, families), contain few "frills". At best, there is usually a common space, (called a "community room") and an on premises laundry facility. Arts and crafts and furnishings are usually obtained through use of tenant association funds, or community and tenant donations. Few units, unless obtained through turnkey arrangements, have what are considered "luxuries" for public housing: carpeting, air conditioning, cable television, etc., all of which are features desired by the relatively younger, more mobile, and frequently economically upscale elderly applicant.

Public housing, at least in the Rochester area, was built in areas impacted heavily by Urban Renewal projects. Consequently, most Authority housing (family and elderly) is located in the urban core of the city. While there are several elderly projects outside the core, these projects rarely exhibit the vacancy problems or lack of waiting list associated with projects located in the central city. Issues, or perceptions of safety and security are paramount in determining housing choices for elderly people, who are least likely to move into areas in which they have had no prior experience, or have no family or friends.

During the 1970s, the New York State Urban Development Corporation (UDC) was established to build much needed housing. While UDC had the power to override local zoning ordinances to build, frequently it took the path of least resistance and built elderly housing (state subsidy plus Federal subsidy plus less vocal local opposition). As a consequence, many areas of New York State, including the Rochester area, have a surfeit of elderly housing. Ironically, the UDC-constructed elderly housing is considered more attractive because of its relative newness, and in some cases, "better" locations. And even more ironic, with the onset of Federal regulations mandating a 30% rent to income ratio, many public authorities with Federal public housing are charging elderly tenants more than they would pay in comparable state aided or BMIR housing.

Growing Old(er) in Public Housing

In-house studies conducted by the Rochester Housing Authority have attempted to pinpoint the aging of elderly residents.In 1970, the majority (89%) of the Authority's elderly tenants were under eighty (80) years of age. By 1988, seventy-five (75%) of the elderly tenants were over seventy-five, with 22% of that group over age 80. Indeed, the Rochester Housing Authority has a group of approximately forty {40} seniors most of whom are between 94 and 102 years of age, and most of whom still retain a high degree of independence in their daily activities. Of this older group, many are long term residents,as are many within the 80 to 90 year old group. As the population "grays", a plethora of health and social problems associated with advancing age come into play. Buildings that were equipped for mobile persons are becoming off-limits to seniors who must use mechanical aids for ambulation. Space and cost- conscious design and equipment of elderly units afford few opportunities to retrofit units for wheelchair bound, or partially-ambulatory tenants. Significant numbers of elderly residents make use of ancillary meal services, and housekeeping assistance is often necessary for residents who can no longer physically perform the work, or have no family to keep up the appearance that the resident is maintaining the unit.

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In attempting to market its units, the Authority has also had to contend with the "image" projected by some of its senior locations. An example is Building "D" which ten years ago, had only one wheelchair bound tenant. Today, the halls of that building are filled with residents in wheelchairs, using walkers, and now, as one long-term resident remarked, has the look of the "County Old Folks' Home". It is indeed an almost impossible task to interest a "young", healthy elderly person in renting in such a building, since they do not see themselves as "old" or as needing the trappings which in their minds characterize one as "old". While it may be excessive hyperbole to say that the halls are "filled", there is nevertheless a marked increase over previous years in the number of less healthy elderly.

Against such a backdrop (increasing numbers of frail elderly, lack of building amenities to attract well elderly, increased housing needs of special populations, a surplus of elderly housing, and aging in place of current residents) creative approaches are called for if a public housing authority is to maximize its occupancy figures, while at the same time attending to the growing need for ancillary services. The Rochester Housing Authority has attempted to address these several points in a variety of ways, ways which may be effectively replicated in other, similar situations.

Facing the Challenge

One of the first items on the Authority's agenda in dealing with its elderly issue was realizing that there was the potential for a crisis, if steps were not taken in a timely manner. Reviewing monthly trends indicated the kinds of new applicants that were being housed. Attempts to coordinate the number and kinds of housekeeping and nursing assistance being offered to residents revealed the extent to which many residents were becoming increasingly dependent on these services. Data from annual reexaminations clearly showed the continual aging of the residents.

The Rochester Housing Authority had two options: One, it could continue to insist that it was first and foremost a housing provider, and thus, would play no role in the provision of ancillary services that residents would increasingly require. Such a rigid position is supported, albeit negatively, by the lack of additional funding from HUD for the provision of social services.The second option was to recognize that the times indeed were changing, and to formulate a plan of action designed to provide necessary services to residents to keep them at a level of independence.

In October 1985, a working group composed of representatives from every sector of the Authority (Housing Management, Tenant Selection, Maintenance, Security, Tenant Social Services, Administration and Section 8 met to consider the growing challenges posed by the elderly tenant population. The "Elderly Task Force", as it became known, met periodically through March 1986 to review and understand demographics, operational responses, and to formulate a plan of action.

The Center for Governmental Research prepared and presented a summary of demographic data on the elderly in Monroe County . Key to the deliberations of the Task Force was data that showed:

1. By, 1990, the elderly would comprise over one-third of all households in Monroe County.

2. The biggest increase in elderly population would occur in the 75 to 85+ age group.

3. Income of elderly suburban residents would increase, and suburban elderly would overwhelmingly own their own homes (75% of suburban elderly).

4. Elderly remaining in the city would be primarily more frail(having one or more significant health problems), female, alone, poor (income below area median), over 85, and at high risk.

These findings were significant to the deliberations of the Task Force because they indicated what staff was beginning to see in new admissions, and what staff could anticipate in future new admissions. The data showed that increasingly, the Authority would draw its residents from an applicant pool that was older, more frail, and less affluent.

The first conclusion of the Task Force was that no "quick fix" would serve to alleviate the situation. It recommended a "continuum of change from this point (1986) to the year 2000 in order to respond to changing demographic and market conditions." Reaffirming its basic mission to provide low and moderate income housing for families and elderly, the Task Force developed short term (from three to five years) actions. At the outset, it was recognized that of key importance was the role staff would play. Reorganization, training, peer support and administrative and board support were all essential if change was to occur.

Training of staff was done using a local consultant who met with the housing managers and assistants involved in elderly housing management as a group. As a result of the large group training, it became obvious that follow-up was desirable on a periodic basis for staff. This consultant meets on a periodic basis with area, or sector staff to discuss issues of conflict resolution, service delivery, and recognition and assessment of at-risk tenants.

Also of major importance was a recognition of the fact that "we are not alone", that is, there were other agencies providing services to the elderly, and that these agencies were frequently experiencing similar frustrations, coupled with a lack of information about what public housing could and could not do. The Social Services department of the Authority initiated "Network" meetings, comprising representatives from agencies either providing services to tenants or engaged in some way with elderly residents. These meetings are held on a quarterly basis, and provide a forum for all parties to exchange information, discuss emerging problems, and to keep systems which are in place functional.

A subgroup of the information sharing process is the "Team Meeting" held on a monthly basis at each elderly site, primarily high-rises. The "team meeting" consists of the building manager, home health aides and housekeeping aides assigned to each site, and nurses assigned to the site.

The route chosen by the Authority recognized the need to maintain the current population, and to effectively service new residents. Utilizing existing services and adapting its internal procedures, RHA began to develop strategies designed to address the problems of its seniors.

Screening and Evaluation

The Authority recognized the importance of adequate diagnostic procedures in the admission of new residents. Working with nursing agencies such as the Visiting Nurse Service, and the County Health Department, the Authority began to request nursing evaluations for new and inplace residents for whom there were any questions concerning ability to live independently. It cannot be emphasized too strongly the importance of the nursing evaluation PRIOR to move-in of a new tenant. Very often, this screening enables us to place new tenants in buildings and/or programs from the outset, rather than moving them in and having to transfer them at a later date. In conjunction with the screening done by the nursing services, Authority staff performing home visits have received training in conducting home interviews and visits with an eye toward determining the ability of the applicant to live independently. A lengthy questionnaire concerning personal habits, ability to take care of one's own business affairs, and ability to recognize and self-treat ordinary medical problems is utilized by RHA staff.

The Programs

For many elderly tenants, ability to continue to live independently is enhanced by securing aide service that provides assistance to the resident with housekeeping, personal care and minor meal preparation. Recognizing that several tenants already had aide service, the Authority attempted to coordinate the number of aides coming into sites, especially high-rise sites. Thus the "SHARED AIDE PROGRAM" was developed. This program is basically a coordination of the various aide services, especially in the high rise buildings. Residents needing a few hours aide service each day are matched with other residents who may need only partial service, thus giving an aide a full day, and eliminating overlapping services provided by differing agencies. Team meetings are held with the Visiting Nurses and aides assigned to the buildings on a regular basis, to discuss resident compliance with medical care or socialization plans, and to evaluate whether a higher level of care may be required.

As stated previously, the Authority began to realize that its new elderly tenant admissions were increasingly in need of additional services, as were many of its in-place residents. Some might have health problems that are somewhat debilitating, yet they do not require a skilled nursing facility, and can manage some degree of independence. To meet the needs of this group, the Authority entered into a cooperative agreement with Family Service ofRochesterin a program called "ENRICHED HOUSING". "Enriched Housing" is located at three sites, (all high rise buildings),and currently numbers eighty units. The Enriched Housing program provides two hot meals a day to program participants in a congregate setting, aide service for limited personal care and housekeeping, and opportunities for socialization. This program allows residents to remain in their individual units while receiving the services necessary to allow them to remain independent. Entry to the "Enriched Housing" program is done on the basis of a nursing evaluation, and an evaluation of the tenant or applicant's ability to be at least partially independent.

What happens with the resident who needs more care than that afforded by the "Shared Aide Program" or the "Enriched Housing Program"? There are elderly residents who may at one time be independent, but due to advanced age, or illness, become less able to care for themselves. Frequently, it is these residents who face the longest wait for admission to skilled nursing facilities because they are Medicaid recipients, and cannot afford to pay toward the cost of skilled nursing care. These residents were frequently held in hospital beds because they were clearly unable to care for themselves, and could not be released to an apartment with only partial assistance from an aide. The Authority, in conjunction with the Monroe County Department of Social Services, devised a program called the "EXTENDED SHARED AIDE PROGRAM", which provides up to twenty-four hour aide service to residents in their own apartments. In addition to the increased aide service, residents may also be assisted with budgeting, and shopping. Nursing service is also available on a regular basis. Although originally designed for existing residents, the program has expanded to include new applicants, although program participation is limited to persons who are active cases with ACCESS, a health management systems agency.Currently there are 22 units set aside for the Extended Shared Aide Program, all of which are studio units, which traditionally have been the hardest units to rent.

Utilization of the various programs offered has run close to 100% overall, at times exceeding projections of use. As each service become established, variations and refinements are suggested to enhance the operation of the program. Staff monitoring the Extended Shared Aide Program saw the need for a few furnished units, especially for new admissions to the program who might formerly have been institutionalized, or who had lost their previous furniture and household goods upon hospital entry. Through the generosity of the Bausch and Lomb Foundation, the Authority secured funds to completely furnish one studio unit per site.

The integrated approach developed by the Authority can best be outlined as:

1. Increased staff training, including staff interaction with other service providers. Staff must learn to recognize the modes of helping elderly residents, recognizing physical and mental deterioration, and managing property effectively without being made

to feel that they are in effect running a nursing home.

2. Screening and evaluation in the admission of new tenants and the retention of residents in place.

3. Provision of services beyond the traditional housing services provided to enable residents to remain as independent as possible for as long as possible. This does not mean that the Authority itself provides the services, but, most importantly, recognizes those agencies within the community that have or can provide the necessary service and invites a cooperative arrangement with those agencies.

Future Projections

The long range plans alluded to previously include several items beyond the control of the PHA. The ability of RHA, as other authorities, to continue to attract tenants with higher incomes would be greatly enhanced by the roll-back of the rent to income ratio to 25%.

Also key in projecting the future of use of publicly assisted elderly housing is the issue of deciding what the resident populations will be, that is, whether public housing authorities wish to begin to plan now for future elderly tenants who require additional services, or have special needs.

Aging in place will continue to present special challenges to housing providers, especially those in the public sector. No matter how much one hears about sale of public housing, it is inconceivable that the private sector would be able to provide the level of housing and ancillary services which many public housing authorities are now finding that they must give to their elderly tenants.The perception of public housing as housing of last resort in many cases mandates a greater role by public housing authorities in the design and execution of Federal and local programs aimed at maintaining independence among the elderly. This may mean adding the issues surrounding the elderly to at least the agenda for discussion in the short term. Important considerations which must be addressed include:

allowing, and encouraging, through the provision of unrestricted funds, the flexibility of local housing providers to respond to local conditions in meeting the housing needs of the elderly;

provision of funding to retrofit units and buildings, and to provide increased social services within elderly buildings;

elimination of regulatory provisions that make it difficult for public housing providers to attract and maintain a relatively "well" and younger elderly population.

The public housing agency of today and the future must come to terms with not only the population it serves but also the very real limitations of its mission and its resources. In terms of the population, it is increasingly evident that it will be progressively poorer, and progressively more frail. It will not suffice to give simply four walls and a door to these elderly residents.

Further, it is clear that this is not simply a problem for the housing providers, but rather, a challenge for the entire society. If not addressed forthrightly, we will either have empty buildings or buildings which cannot be called "home".

ABOUT THE AUTHOR

Viola Brown-Kribich has been employed by the Rochester Housing Authority for the past thirteen years. During this time, she has worked in several facets of the Authority's operations, including the Section 8 Housing Assistance Program, and the Federal conventional housing program, where she managed both family and elderly units. She has also supervised the Tenant Selection office of the Authority, and developed many of the instruments used in evaluating elderly and other applicants. Currently, she is the Communications Specialist for the Authority.

Ms. Brown-Kribich attended Cornell University and the State University of New York. In addition to practical experience gained from working and volunteering with the elderly, she has participated in many courses and workshops designed to deal with the problems of the elderly, most notably minority elderly. She also serves as an unpaid consultant to the Hon. David F. Gantt (N.Y. State Assembly) regarding the needs of urban elderly populations.

TESTIMONY BEFORE THE U.S. HOUSE OF REPRESENTATIVES
BEFORE THE
SELECT COMMITTEE ON AGING
EDWARD R. ROYBAL, CHAIRMAN

by

JAY LANE, DIRECTOR OF SOCIAL SERVICES
MANCHESTER HOUSING AUTHORITY
MANCHESTER, NEW HAMPSHIRE

Mr. Chairman, thank you for allowing me the opportunity to provide written testimony on the development of Congregate Housing Services. My name is Jay Lane. I am the Director of Social Services for the Manchester Housing Authority, Manchester, New Hampshire.

In my testimony, I will refer to an evaluation which was recently conducted on the New Hampshire Congregate Housing Services Program. Specifically, I will discuss comparative cost of Congregate Services versus other alternative housing arrangements. In addition, I will touch on the two Congregate Programs sponsored by the Manchester Housing Authority. I will end my discussion by pointing out in detail why CHSP has become part of the continuum of care for the elderly population in New Hampshire.

Finally, I would like to include a copy of the evaluation which was prepared by members of the staff at the Human Services Development Institute, University of Southern Maine.

In 1987, the New Hampshire Legislature appropriated $240,000 for the development of a two-year pilot Congregate Housing Services Program. As a result of their experience in implementing the HUD CHSP model program, several years earlier, the Manchester Housing Authority was chosen as the site for the pilot program. Approximately 15 months into the implementation process, the University of Southern Maine conducted a complete evaluation of all aspects of the program.

The results proved conclusively that CHSP is both cost effective and has a serious impact on the clients' quality of life.

Results of the evaluation concluded that:

- From July 1987 - September 1988, the State of New Hampshire spent a total of $125,505 in grant funds to operate the Pariseau CHSP.
- This total represents an actual cost per client month of $463.12.
- For the same time period, estimated costs to taxpayers in the State of New Hampshire for the 40 clients in alternative residential settings would have been $201,802, or $744.66 per client month.
- For the 21 clients who would have been in nursing homes if the CHSP did not exist, the State of New Hampshire would have paid $1,048 per client month in its share of Medicaid costs. This is more than twice the cost per client month as the CHSP. An additional $1,049 per client month, as the Federal Medicaid share, would also have been spent on these clients, but was instead available for other Medicaid-funded services.
- Clients who would have been in residential care facilities or their own homes would have cost the state less than the CHSP, but the utilization of essential services by clients in these other settings is questionable since out-of-pocket costs would have been significant.

The impact of the CHSP on clients quality of life was determined by reviewing client records in detail, especially initial assessments and three-month progress notes written by the CHSP Director.

Results indicated that:

- The CHSP has had a positive impact on the quality of clients' lives in the specific area of social support and engagement in activities. This is very important because a review of clients' characteristics at admission to the CHSP showed that they were socially isolated and rarely engaged in activities outside the home.

- All clients utilize meals offered by the program, a large majority use housekeeping services, and a minority use personal care and transportation services. Thus, the CHSP has met the specific needs of clients resulting from physical health limitations.
- The Professional Advisory Committee has successfully targeted moderately impaired, socially isolated older adults as clients most apt to benefit from the CHSP.

In deciding to undertake the development of CHSP, the Manchester Housing Authority recognized that tenants residing in facilities constructed in the late 60's and early 70's were aging in place. In fact, recent statistics indicate that roughly 12% of the elderly tenants residing in Public Housing at this time would be suitable candidates for Congregate Housing. It became apparent to the Manchester Housing Authority that suitable alternatives did not exist. Therefore, new ideas had to be developed and Congregate Housing has proven to be an extremely viable alternative.

Research conducted by organizations such as the Urban Institute in Washington and the Housing Research and Development Program at the University of Illinois have documented that at the very least 10% of the people presently residing in nursing homes nationwide were placed there prematurely. The cost for the taxpayers for needless institutionalization is staggering. It is also senseless given that CHSP costs roughly about one third that of nursing home care as demonstrated in Manchester, NH.

Clearly the time for expansion of CHSP has come. A number of states across the country have either passed legislation or are in the process. States are beginning to recognize that C.H.S.P. is part of the continuum of care which needs to be explored further. Elected representatives of the taxpaying community are also becoming acutely aware that there are more solutions to our aging problems then institutional- ization.

In closing, I applaud your efforts on behalf of the elderly population of this country. Again, thank you for allowing me the opportunity to discuss Congregate Housing Services.

JL:jas

Evaluation Report for the

Congregate Housing Services Program
Pariseau Building,
Manchester, New Hampshire

submitted to:
Manchester Housing Authority
Manchester, New Hampshire

submitted by:
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ACKNOWLEDGEMENTS

This evaluation would not have been possible without the assistance of several people at the Manchester Housing Authority (MHA). First and foremost, Susan Kretschmer provided us with much detailed information about the Congregate Housing Services Program (CHSP) at the Pariseau Building. As Director of the Pariseau CHSP, Susan found time in her very busy schedule to explain the program's history, policies, and sources of client information. Her professionalism, patience, and good humor were all greatly appreciated, and her pride in the program was always evident. Jay Lane, Director of Social Services at the MHA, coordinated our work and gave helpful insights into the CHSP at several important junctures throughout this evaluation project. Finally, Steve Dorr, Finance Director at the MHA, always provided budget information in a timely fashion.

Elsewhere in New Hampshire, several program officials provided us with critical information about public costs for in-home and nursing home services. They are listed in Appendix A.

At the Human Services Development Institute, Victoria Russell, Administrative Assistant, prepared all drafts of this report. Her efficiency and organization were invaluable in helping us complete this project.

Richard H. Fortinsky

EXECUTIVE SUMMARY

The purpose of this evaluation was to provide evidence to the New Hampshire State Legislature about the cost-effectiveness of the state-funded Congregate Housing Services Program (CHSP), located at the Pariseau Building in Manchester, New Hampshire. This evaluation was conducted by the Human Services Development Institute, University of Southern Maine. Specific objectives were to:

- determine the extent to which cost savings are achieved by the CHSP; and
- determine how the CHSP affects the quality of life among clients in the Pariseau Building.

In order to address these objectives, this evaluation looked in detail at the first forty (40) clients who were admitted to the CHSP during the time period July 1987 through September 1988, or the initial fifteen (15) months of program operation. Individuals admitted to the CHSP had an average age of 75 years, needed assistance preparing meals and conducting housekeeping, shopping, and laundry, and were socially isolated in their previous living situation. Many transferred to the CHSP from either nursing homes or residential care facilities in New Hampshire.

In order to estimate cost savings, the actual costs to the State of New Hampshire for operating the CHSP were compared to estimated public costs for these clients if the CHSP did not exist. To determine the latter estimates, it was assumed that the 40 clients would have resided in either nursing homes, residential care facilities, or their own homes or apartments. For most clients, this assumed alternative residence was actually where they had lived prior to entry into the CHSP.

Among clients who would have lived in nursing homes without the CHSP, Medicaid was the assumed payment source, and the state's share was calculated at 50 percent of total Medicaid costs. For clients who would have resided in a residential care facility, the state's share was calculated by subtracting their monthly adjusted gross income from $615.00, which is the maximum state contribution. For clients who would have remained at home, the public share of meals, homemaker, and personal care costs was calculated at 54 percent of total service costs. All costs were first computed on a monthly basis, and then multiplied by the number of months each client actually resided in the Pariseau Building during the fifteen month study period. This process yielded total estimated public costs for each client if the CHSP did not exist.

Results indicated that:

- From July 1987 - September 1988, the State of New Hampshire spent a total of $125,505 in grant funds to operate the Pariseau CHSP.
- This total represents an actual cost per client month of $463.12.
- For the same time period, estimated costs to taxpayers in the State of New Hampshire for the 40 clients in alternative residential settings would have been $201,802, or $744.66 per client month.
- For the 21 clients who would have been in nursing homes if the CHSP did not exist, the State of New Hampshire would have paid $1,048 per client month in its share of Medicaid costs. This is more than twice the cost per client month as the CHSP. An additional $1,049 per client month, as the Federal Medicaid share, would also have been spent on these clients, but was instead available for other Medicaid-funded services.
- Clients who would have been in residential care facilities or their own homes would have cost the state less than the CHSP, but the utilization of essential services by clients in these other settings is questionable since out-of-pocket costs would have been significant.

The impact of the CHSP on clients' quality of life was determined by reviewing client records in detail, especially initial assessments and three-month progress notes written by the CHSP Director. Results indicated that:

- The CHSP has had a positive impact on the quality of clients' lives in the specific area of social support and engagement in activities. This is very important because a review of clients' characteristics at admission to the CHSP showed that they were socially isolated and rarely engaged in activities outside the home.

- All clients utilize meals offered by the program, a large majority use housekeeping services, and a minority use personal care and transportation services. Thus, the CHSP has met the specific needs of clients resulting from physical health limitations.

- The Professional Advisory Committee has successfully targeted moderately impaired, socially isolated older adults as clients most apt to benefit from the CHSP.

Based on these findings, several recommendations were made, including:

- The State of New Hampshire should view the Pariseau Building CHSP as a successful model, considering the cost of the program relative to alternatives and its positive effects on quality of life for a significant number of clients.

- Improved data collection procedures should be implemented to monitor client progress. Quarterly reviews by the Professional Advisory Committee should include completion of a more standardized form very similar or identical to the Initial Assessment Form. This would enable program managers to observe changes over time in specific areas covered by the form. Any additional areas of interest could be added to initial and followup assessment forms.

- Transportation services should be reassessed to determine if they are suited to the needs of Pariseau CHSP clients. The low utilization rate suggests that clients do not see value in the purposes for which transportation is currently available.

- For rural areas in New Hampshire, it is desirable to design a "decentralized model" of the CHSP, where it is not feasible to construct a building such as Pariseau or Gallen. The goal would be to coordinate the equivalent package of services as available in the existing CHSP, but deliver the services to clients' own homes, with the exception of meals, which could be offered in a central location. The target group should be chosen carefully to include clients with needs in the areas of meal preparation, shopping, homemaker-related areas, and social supports. This should be the next challenge to the state in offering innovative home and community-based services to moderately impaired older adults.

I. INTRODUCTION

Congregate housing services is a relatively new concept in caring for the growing number of frail and moderately impaired elderly. Originally created at the Federal level by an act of Congress in 1978, the Congregate Housing Services Program (CHSP) is seen by many as a promising method of integrating housing, health and social services for older and disabled people. Currently, there are 63 federally-funded CHSP sites, including one located at the Gallen Building in Manchester. The federal CHSP program was upgraded in 1987 from a demonstration to a permanent program.

As a result of the success of the Gallen Building program, a bill was submitted to the New Hampshire Legislature calling for the establishment of a model state-funded CHSP program. Passed in May 1987, the Act[1] states that "congregate services are designed to offer an innovative, proven cost-effective means of delivering supportive services which will enable frail elderly, temporarily disabled, and handicapped individuals to maintain their dignity and independence and to avoid costly and unnecessary institutionalization." This state-funded program is located at the Pariseau Building, administered by the Manchester Housing Authority. Services provided to eligible clients include:

- low rent, publicly-owned housing, including a central dining facility;
- two nutritionally balanced meals, 7 days per week;
- regular assistance with housekeeping;
- personal assistance;
- transportation to scheduled physician appointments;
- administrative support services, including case management; and
- daily supervision of Pariseau residents.

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[1] Chapter 232, HB 273-FN-A

In addition, the program schedules periodic on-site clinics providing podiatrist services, eye tests, blood pressure readings, and health promotion information. The availability of these services is expected to provide clients with a greater sense of well-being, while reducing the state's total cost of nursing home and other health care services.

This report presents results of an independent evaluation of the state-funded CHSP at the Pariseau Building. The evaluation, conducted by the Human Services Development Institute (HSDI), University of Southern Maine, looks at the cost-effectiveness of the CHSP and includes recommendations for improving the program so that it may be replicated or adapted elsewhere in New Hampshire.

II. APPROACH

The purpose of this evaluation was to provide evidence to the New Hampshire Legislature about the state-funded CHSP's cost-effectiveness. Specific objectives were to:

- determine the extent to which cost savings are achieved by the CHSP; and
- determine how the CHSP affects the quality of life of the clients in the Pariseau Building.

The Pariseau CHSP began July 1, 1987, and this evaluation reviewed the first fifteen (15) months of program operation. As of September 30, 1988, a total of forty (40) persons had been served by the program. For purposes of this evaluation, HSDI included information from all 40 clients who had been served by the program through September 30, 1988.

A. Determination of Cost Savings

The two main questions addressed by this evaluation were: (1) What would costs to the State of New Hampshire have been for these clients if the CHSP did not exist? (2) How do these costs compare to the costs of operating the CHSP?

In order to answer these questions, several types of cost information were obtained. First, the Finance Director of the Manchester Housing Authority supplied HSDI with actual program expenditures for the Pariseau CHSP during the 15 month evaluation period. Since the program was not in full operation throughout this period, however, projected costs for the time period July 1988 - June 1989 were also provided. These latter costs reflect full staffing and utilization of CHSP services. Both sets of data were used to calculate costs of operating the CHSP.

Estimates of what costs would have been for the State of New Hampshire[2] without the CHSP were derived using several assumptions. Based on a review of CHSP records, an alternative living arrangement was identified for each of the 40 clients. Three alternative living arrangements were used: nursing home; residential care facility; and independent living (own home or apartment). In most cases, this was the actual place of residence at the time the client applied for admission to the Pariseau CHSP. For the group of clients who transferred to the CHSP from either a hospital or their own homes in a very vulnerable situation, the Director of the CHSP determined the most realistic alternative living arrangement. This judgement was made after a thorough review of records, which contained information from several members of the Professional Advisory Committee (PAC), which discusses every potential client at the time of application. Thus, the first major assumption was that each client would have resided in one of the three alternative settings for the entire time that he/she resided at the Pariseau Building as a CHSP recipient. Although this assumption can be challenged (e.g., persons would not have stayed at home for several months, but would have gone to a nursing home), the important point is that consistency was used across all clients in making these judgements.

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[2] For purposes of this evaluation, costs to the "State of New Hampshire", "State" costs, and "public" costs all refer to state and county costs.

A total of 21 clients would have resided in a nursing home without the CHSP, according to the assumptions used. Of these, 10 were transferred to the CHSP directly from nursing homes. The remainder were successfully diverted from nursing homes to the CHSP. These people were referred to the CHSP by hospitals and residential care facilities, or lived in their own homes and were referred to the CHSP.

In calculating costs for the nursing home group, it was assumed that all 21 clients would have been eligible for Medicaid as a payment source. This assumption was made because nearly all had monthly incomes under $600 (median income was $470 per month), and all qualified for residence in Manchester public housing. Costs were estimated by using the statewide average monthly Medicaid nursing home rate ($2,097). This figure was multiplied by the number of months which the 21 clients resided at the Pariseau Building through September 30, 1988. The result yielded the estimated total Medicaid nursing home cost for these clients. One half of this total represented New Hampshire's costs for the nursing home group if the CHSP did not exist, because the state's share of Medicaid costs is 50 percent.

Public costs for clients who would have been in residential care facilities (RCF) without the CHSP (N=8) were then estimated. Five of these clients transferred to the CHSP from an RCF because of ambulation problems (no elevators in RCFs) or because group meals were no longer available at the RCFs. The remaining three clients with ambulation and meal preparation assistance needs entered the CHSP from hospital and home settings. Since the State of New Hampshire pays an RCF up to $615 per month depending on a client's income, each client's adjusted gross income was subtracted from this figure. The total state share for each client was calculated by multiplying the state's contribution per month by the number of months which the client resided at the Pariseau Building through September 30, 1988.

Finally, state costs for the eleven clients who were assumed to have lived in their own homes or apartments without the CHSP were estimated. This group of clients already resided at the Pariseau Building when the CHSP began in July 1987. Six of these clients were admitted to the CHSP on a "temporary" basis, so that they could receive prepared meals in the central dining facility, housekeeping services, and personal care services during a period of time when their health was especially frail. For this temporary group, the CHSP served the vital function of providing essential services which allowed them to remain in their own apartments in the Pariseau Building. Four of the remaining five persons in this group chose to withdraw from the CHSP after a short period of time on the program, primarily because they did not wish to participate in the group meal. As of September 30, 1988, all eleven clients in this group still resided in the Pariseau Building and only one was a CHSP client.

To estimate costs for this group, the CHSP Director determined what types of services each client would have required to remain at home as long as possible. Only meals, personal care assistance, and homemaker services were considered, since these are the services provided by the CHSP. It is important to remember that six of these clients (i.e., the "temporary" clients) may not have maintained an independent living situation without support from the CHSP, and therefore may have entered a nursing home or RCF at greater expense to the state.

The public share of costs for meals, homemaker services, and personal care services is not usually calculated on a per client basis. Discussions with several state and service organization officials[3] led to the decision to assume that 54 percent of total unit costs were paid by public sources for these home-based services. Based on each client's estimated service needs, a total monthly cost was calculated. This figure was then multiplied by the number of months which the client resided at the Pariseau Building during the fifteen month study period to obtain total estimated public costs per client.

Once total costs were calculated for each client in the three alternative residential groups, group total costs were derived. These totals were divided by the number of client months which group members resided in the Pariseau Building, to obtain a "cost per client month" figure. These figures were finally compared to the actual cost per client month to the state for administering the Pariseau CHSP. A summary of cost results appears in Table 5 and results are discussed in Section III.B.

B. Determination of Quality of Life Impact

A secondary focus of this evaluation was the effect of the CHSP on the lives of clients admitted to the program. A key aim of the legislation which created the CHSP was to provide services that would maintain the dignity and independence of frail elderly and handicapped individuals.

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[3] See Appendix A for officials contacted for this portion of the evaluation, as well as actual unit costs used in these calculations.

In order to measure the impact of the CHSP on the clients' quality of life, client records were reviewed to determine how clients had progressed during their tenure in the CHSP. Information from initial assessment forms (See Appendix B), quarterly followup narratives, and index cards maintained for each client was reviewed for this purpose. After conducting a content analysis of these records, categories were developed to describe how well the clients had progressed while in the program.

All 40 clients who took part in the CHSP from July 1987 through September 1988 were included in the quality of life evaluation. Although there was little information available for some of the clients who were in the CHSP for a brief period of time (i.e., temporary clients or those who left voluntarily), their experience while on the program was still valid and useful in determining the overall effectiveness of CHSP. In addition to describing results from the quarterly review documents, details of client characteristics at admission are included in this report to give the reader a flavor for the high-risk situations these clients were in at the time they applied for the CHSP.

III. FINDINGS

A. Description of Client Population

This section describes selected sociodemographic information about the 40 clients served by the CHSP during its first fifteen months of operation (July 1987-September 1988). Of these 40 CHSP clients, 24 (60 percent) were female and 16 (40 percent) were male. Clients' ages ranged from 58-94, with a mean of 75 years. The length of time clients spent on the program varied from less than 1 month to 15 months, with a mean of 6.75 months.

All clients were receiving Social Security payments as their primary source of income. The amounts ranged from $202.50/month to $948.30/month. The mean Social Security amount was $436.27, while the median amount was $423. Fifteen clients also had some other source of income. When these amounts were added, the clients' total income ranged from $202.50/month to $1392.09/month. The mean monthly amount of total income was $506.14, while the median income was $470.

Table 1 displays the most commonly indicated health problems experienced by the 34 CHSP clients for whom data were available. Most (31) had 2 or more problems, with heart disease being the most frequent (35.3 percent). Among the various heart ailments experienced were arteriosclerotic heart disease, angina, cardiac arrhythmia, and congestive heart failure. Nearly one quarter had vision problems, ranging from "failing vision" to blindness and/or cataracts, and an equal number suffered from arthritis. Ambulatory, hearing, and circulatory problems were also reported by CHSP clients.

TABLE 1

Health Problems Experienced by Clients at the Time of Application to the CHSP (N=34)

Problem	Number of Clients	Percent of Total
Heart Disease, all types	12	35.3%
Blind/Vision Problems (including cataracts)	8	23.5%
Arthritis	8	23.5%
Ambulatory Problems	6	17.6%
Hearing Problems	4	11.8%
Dizziness Poor Balance	4	11.8%
Circulatory Problems	4	11.8%

Based on data abstracted from the initial assessment form, fewer than half (43 percent) of the clients fully understood their health and medical problems.

Table 2 shows the number of clients needing help with their activities of daily living (ADL). Due to missing data on the initial assessment form for specific ADLs, the sample size for Outside Mobility was 31; for Medication, 32; for Meal Preparation, 34; and for all other ADLs, 35. It is important to note the number of clients needing help with instrumental activities of daily living (IADL). There are 5 activities in which over 90 percent of the clients need help and all 5 are IADL's. Fewer numbers of clients needed assistance with the personal activities of daily living (PADL).

In summary, more than 60 percent of clients needed assistance with bathing, ambulation, and all IADLS. This table illustrates the physical health limitations experienced by persons who apply for CHSP services, and suggests that the program targets moderately impaired older persons as originally intended, especially those who could not prepare meals for themselves or conduct other instrumental activities such as shopping, laundry, and housekeeping.

TABLE 2

Limitations in Activities of Daily Living at the Time of Application to the CHSP

Characteristics	Number of Clients Needing Assistance or With Problems	Percent of Total
Meal Preparation	34	100.0%
Shopping	32	91.4%
Laundry	32	91.4%
Housekeeping	32	91.4%
Outside Mobility	30	96.8%
Bathing	22	62.9%
Ambulation	21	60.0%
Medication	8	25.5%
Transfer	4	11.4%
Dressing	4	11.4%
Telephoning	3	8.6%

Table 3 displays the social supports clients had at the time of the assessment. This table suggests a severely limited degree of contact and socialization for a large number of clients. Almost one third (32.4 percent) had contact with friends less than once a month. Only 2 clients participated in regular activity outside the home, while over half (54.3 percent) seldom took part in activities outside their home. Only 17.6 percent of the clients felt they had someone with whom they could discuss most things.

The data Table 3 clearly show a high level of isolation from others prior to entering the CHSP. It is also significant to note that only 3 clients were able to obtain all the appropriate services for independent living. The CHSP,

TABLE 3

Social Support Characteristics at the Time of Application to the CHSP

Characteristics	Number of Clients	Percent of Total
Contact with Relatives		
Weekly	24	68.6%
Monthly	4	11.4%
Less Than Once/Month	7	20.0%
Total	35	
Contact with Friends		
Weekly	15	44.1%
Monthly	8	23.5%
Less Than Once/Month	11	32.4%
Total	34	
Phone Contact with Friends/Relatives		
Weekly	24	70.6%
Monthly	3	8.8%
Less Than Once/Month	7	20.6%
Total	34	
Communication		
Has Someone with Whom to Discuss Most Things	6	17.6%
Has Someone with Whom to Discuss Major Problems	26	76.5%
No One with Whom Client Feels Comfortable Discussing Concerns	2	5.9%
Total	34	
Activities/Socialization		
Regular Activity Outside the Home	2	5.7%
Sporadic Activity Outside the Home	14	40.0%
Seldom Participates in Activities Outside the Home	19	54.3%
Total	35	
Other Support Systems		
Obtains Appropriate Service for Independent Living	3	9.7%
Receives Some Services but Needs Not Totally Met	24	77.4%
Needed Services Not Received	4	12.9%
Total	31	

therefore, targets services for both physically impaired and socially isolated elders. These findings are important for understanding the types of persons most likely to be referred to congregate housing programs.

The Manchester CHSP uses a scoring format based on ADL and social support information on the initial assessment form to determine clients' eligibility and priority for the program. A score of 1 to 18 is Priority 3 (least need), 19 to 36 is Priority 2, and 37 to 54 is Priority 1 (greatest need). Priority 3 is not eligible - anyone scoring fewer than 19 points is not accepted into the program. Among the 35 clients with this information available, 4 clients were Priority 1 and 31 were Priority 2. Scores ranged from 19-40, with 31.6 being the mean. The summary score reflects the moderate to severe problems indicated for the individual items in Tables 2 and 3.

Turning to services used while in the CHSP program at the Pariseau Building, Table 4 shows the kinds of services that were utilized in the clients' most recent active month. Figures were calculated in one of two ways. For clients in the program as of September 30, 1988, the total number of units received during September, 1988 were recorded. For temporary clients and clients who left voluntarily, the number of units received during their most recent complete calendar month was used (6 clients spent less than one full calendar month in the program and are not included in this table). Figures for mean and range were based only on those clients who actually utilized the services.

TABLE 4

Kinds of Services Utilized by CHSP Clients in Most Recent Active Month

Type of Services Used	Percent of Clients Who Received Any	Mean	Range
Meals	100.0%	54.5 meals	24-62 meals
Housekeeping	73.5%	5.7 hrs.	2-10 hrs.
Personal Care	26.5%	3.9 hrs.	2- 5 hrs.
Transportation	14.7%	3 trips	1- 6 trips

Findings indicate that all clients used the meal service and a large majority used housekeeping services available through the CHSP. Much less used were personal care and transportation services. Transportation is only available for physician or other medical visits, and many clients apparently have other means for getting to these important visits (e.g., family members). If transportation were available for shopping, however, it might be used more often, since this was a limitation of most clients at application to the CHSP (see Table 2). Except for transportation, the services available through the CHSP are clearly utilized by a large number of clients, and fit the needs exhibited at the time of application to the program.

B. Cost Estimates with and without the CHSP

All cost calculations are summarized in Table 5. Results in Table 5 compare actual expenditures by the State of New Hampshire to operate the CHSP at the Pariseau Building during the time period July 1987-September 1988, with estimated state expenditures for the 40 clients without the Pariseau CHSP during the same time period. Projected state costs for fiscal year 1989 to operate the program are also included to show per client month costs at full occupancy.

Looking first at actual and projected costs (top of Table 5), it is important to note that these figures include only the state CHSP grant portion (i.e., not client fees or interest income). These figures also do not include housing costs. The state grant source of funds most accurately reflects the true cost to the state associated with operating the Pariseau CHSP, and is the most valid point of comparison against estimated state costs without the CHSP.

Findings indicate that for the initial 15 months of the Pariseau CHSP, the State of New Hampshire spent a total of $125,505 to operate the program, exclusive of housing costs. Expenditures for fiscal year 1988 were somewhat lower than expected because it was the startup year, while the first quarter of fiscal year 1989 reflects the program at full operational level. When this cost total is divided by the total number of months that the 40 study clients resided in the Pariseau Building through September 1988 (i.e., 271 client months), Table 5 shows that the actual cost per client month to the State of New Hampshire for that time period was $463.12.

Projected costs to the state for fiscal year 1989 show total operating costs of $128,834. Assuming that the CHSP operates at full occupancy for the entire year (i.e., 30 units occupied for 12 months, or 360 client months), results indicate a cost to the state per client month of $357.87.

Turning to the estimated costs to the State of New Hampshire without the CHSP, Table 5 presents calculations for the three separate alternative living arrangement groups[4]. According to these estimates, the nursing home group

---

[4] The approach used to derive these groups is detailed in Section II of this report.

TABLE 5

Summary of Cost Calculations, CHSP Evaluation

STATE CHSP GRANT COSTS[1]

July 1987 - September 1988		July 1988 - June 1989	
Actual State Grant Costs		Projected State Grant Costs	
$ 91,211	(Actual State Grant Costs, FY88)*	$137,197	(Projected State Grant Total Costs, FY89)
34,294	(Actual State Grant Costs, July 1988-Sept. 1988)**	- 8,363	(State Share of Evaluation Costs)
$125,505	(Net State Grant Costs, July 1987-Sept. 1988)	$128,834	(Projected Net Costs)
÷ 271	(# client months, July 1987-Sept. 1988)	÷ 360	(# client months at full occupancy)
$ 463.12	per client month	$357.87	per client month

* Start-up Year
**Excludes Evaluation Costs

COSTS TO STATE WITHOUT CHSP (ESTIMATED)[2]

Nursing Home		Residential Care Facility (RCF)		Own Home	
$189,688	(Total Costs)	$ 8,165	(Total Costs)	$3,949	(Total Costs)
÷ 181	(Client Months)	÷ 55	(Client Months)	÷ 35	(Client Months)
$ 1,048	per client month	$148.45	per client month	$112.83	per client month

Nursing Home and RCF Combined:

$197,853 ÷ 236 = $838.36 per client month

All 3 Combined:

$201,802 ÷ 271 = $744.66 per client month

---

[1] Based on figures supplied by Steve Dorr, Finance Director, Manchester Housing Authority. Costs are exclusive of housing costs.

[2] Estimated for the time period July 1987-September 1988; see Text for assumptions.

TABLE 5 (Cont.)

TOTAL EXPENDITURES FOR CHSP[1]

Actual Costs July 1987 - September 1988		Projected Costs July 1988 - June 1989	
102,715	(Actual FY88 Costs)[2]	157,336	(Projected FY89 Costs)
30,445	(Actual Costs, July-Sept.'88[3]	- 9,591	(Evaluation Cost)
$133,160	(Net actual costs, July '87 - Sept. '88)	$147,745	(Projected Net Cost, FY89)
÷ 271	(Actual client mos., July '87- - Sept. '88)	÷ 360	(# client mos. at full occupancy)
$491.37	per client month	$410.40	per client month

---

[1] Based on Figures supplied by Steve Dorr, Finance Director, Manchester Housing Authority. Costs shown are exclusive of housing costs.

[2] Start-up Year

[3] Excludes Evaluation Costs

(N=21) would have cost the state a total of $189,688 through its share of Medicaid payments. As mentioned above, the statewide average monthly Medicaid nursing home cost to the state is $1,048 (50 percent of $2,097). When compared to the $463.12 per client month figure representing actual costs for the CHSP, these findings suggest that state costs for the CHSP are less than one-half what they would have been for the nursing home group.

Table 5 also shows that the state would have spent less for clients who would have otherwise lived in RCFs (N=8) or in their own homes (N=11). Clients in RCFs would have cost New Hampshire an estimated total of $8,165 ($148.45 per client month), while clients in their own homes would have cost an estimated $3,949 ($112.83 per client month).

When all three groups' cost estimates are combined, Table 5 reveals that the state would have paid a total of $201,802 during the fifteen month period for these 40 clients without the CHSP. This figure is 61 percent higher than the $125,505 that the state actually spent to operate the program in the Pariseau Building between July 1987 and September 1988.

Finally, Table 5 summarizes total actual and projected CHSP expenditures, including all sources of funds (state grant, client fees, and interest income). Results indicate total actual expenditures during the first 15 months of $133,160, or $491.37 per client month. Projected total expenditures for fiscal year 1989 for program operations are $147,745, or $410.40 per client month. Readers of this report are advised to examine the differences among these cost calculations carefully.

C. **Impact of CHSP on Clients' Quality of Life**

Table 6 summarizes the characteristics that occurred most frequently on clients' Quarterly Reviews (N=24). The Quarterly Review is a narrative report that summarizes the CHSP Director's impressions of the clients. There are no standard responses specified. Of the impressions noted in the reviews, the most frequently cited are all positive (Sociable, Doing Well, Engages in Activities). Of the "negative" impressions, none were indicated for more than 29.2 percent of the clients.

Findings indicate that more than one-half of clients with quarterly reviews were socializing and doing well, particularly at meal times which are the center of most activities. One-third of clients engaged in other activities offered by the CHSP, both in the dining room area and outside the Pariseau Building at events organized by CHSP staff. These all reflect positive impacts on quality of life, as most clients were severely socially

TABLE 6

Impact of CHSP on Clients Based on Quarterly Reviews (N=24)

Characteristics	Number of Clients	Percent of Clients
Sociable, Friendly, Talkative	13	54.2%
Doing Well	13	54.2%
Engages in Activities	8	33.3%
Complains About Meals	7	29.2%
Refuses Services	6	25.0%
Health Deterioration	3	12.5%
Problem With Alcohol	2	8.3%
Angry	2	8.3%

isolated prior to participation in the CHSP, as discussed above (see Table 3). A minority of clients have had negative experiences, as evidenced by complaints about meals and refusal of services. Very few, however, experienced health declines or other health problems during their tenure as CHSP clients.

For the remainder of clients who had no quarterly reviews, the same types of comments were noted on index cards and other progress notes. Positive comments greatly outnumbered negative comments.

Overall, these data indicate that the CHSP has had a positive impact on many clients' lives, especially in the crucial area of social support. Improved data collection to measure quality of life impact more specifically is a strong recommendation of this evaluation, especially if the state wishes to replicate or adapt this program elsewhere.

When the study period for this evaluation ended (September 30, 1988), there were 23 active CHSP clients. Of the 17 inactive clients, 10 had either been temporary clients or left the program voluntarily (all continued to reside at Pariseau), 5 had died and 2 had been admitted to nursing homes. It is important to note that every client who entered the CHSP from outside the Pariseau Building has remained in the program. This attests to the value of providing housing and supportive services to frail elderly who otherwise would not have been able to maintain independent living arrangements.

IV. CONCLUSIONS AND RECOMMENDATIONS

This evaluation has found that the State of New Hampshire spent $125,505 during the first fifteen months of the Pariseau Building CHSP for program operations. Based on detailed assumptions about alternative residential settings for the program's first 40 clients, it was estimated that the state would have spent more than $201,000 for services for these persons if the CHSP did not exist. The CHSP is especially less costly than nursing home services, where it was estimated that the state would have paid more than twice as much per client month as for the CHSP. Further, this evaluation found that for a significant number of CHSP clients, the program had a positive impact on the quality of their social support system. This was evidenced by many clients participating actively in meals and other activities who had previously been severely socially isolated. Based on these findings, it is concluded that the state-funded model CHSP at the Pariseau Building in Manchester is a cost-effective program and is meeting the aims spelled out in the enabling legislation.

The State of New Hampshire should, therefore, view the Pariseau Building CHSP as a successful model for future state-funded initiatives in the area of congregate housing for frail and disabled older adults. It is especially useful for persons who are socially isolated, whether in rural or urban areas, and who need assistance in activities of daily living such as meal preparation, shopping, homemaking, and transportation. Personal care services are also utilized by those who need assistance in bathing and dressing activities.

Recommendations for improving the Pariseau CHSP, and for those considering replicating or adapting this program elsewhere in New Hampshire, include:

- Improved data collection procedures should be implemented to monitor client progress. Quarterly reviews by the Professional Advisory Committee should include completion of a more standardized form very similar or identical to the Initial Assessment Form. This would enable program managers to observe changes over time in specific areas covered by the form. Any additional areas of interest could be added to initial and followup assessment forms.
- Transportation services should be reassessed to determine if they are suited to the needs of Pariseau CHSP clients. The low utilization rate suggests that clients do not see value in the purposes for which transportation is currently available.
- For rural areas in New Hampshire, it is desirable to design a "decentralized model" of the CHSP, where it is not feasible to construct a building such as Pariseau or Gallen. The goal would be to coordinate the equivalent package of services as available in the existing CHSP, but deliver the services to clients' own homes, with the exception of meals, which could be offered in a central location. The target group should be chosen carefully to include clients with needs in the areas of meal preparation, shopping, homemaker-related areas, and social supports. This should be the next challenge to the state in offering innovative home and community-based services to moderately impaired older adults.

APPENDIX A

OFFICIALS CONTACTED FOR ESTIMATING STATE COSTS WITHOUT THE CHSP, AND UNIT COSTS FOR HOME-BASED SERVICES USED IN CALCULATIONS

Officials:

Carol Blank
VNA Personal Services
Manchester, N.H.

Jeanette Gagnon
Supervisor of Direct Services
Division of Elderly and Adult Services
New Hampshire Department of Health
and Human Services

Julie Goulet
Manchester Regional Office
Division of Elderly and Adult Services
New Hampshire Department of Health
and Human Services

Jill Guild, Supervisor
Child and Family Services of New Hampshire
Manchester, N.H.

Elaine Lyons
Executive Director
St. Joseph's Community Services, Inc.
Merrimack, New Hampshire

Unit Costs:

Meals:	Unit cost to agency	=	$5.38
	Public contribution (54 percent)	=	$2.90
Homemaker:	Unit cost	=	$8.80 per hour
	Public contribution @ 54 percent	=	$4.75 per hour
Personal Care:	Unit cost	=	$4.00 per hour
	Public contribution @ 54 percent	=	$2.16 per hour

APPENDIX B

INITIAL ASSESSMENT FORM

Manchester Congregate Housing
Services Program

CHSP HEALTH ASSESSMENT

DATE: ____________________

NAME: ____

ADDRESS: ____

TELEPHONE: ____

REQUESTED BY: ____

REFERRED TO: ____

PHYSICIAN: ____

RESPONSIBLE PERSON: NAME ____

RELATIONSHIP ______________ PHONE ___________

PHYSICAL HEALTH PROBLEMS/LIMITATIONS:

____

____

____

____

____

1. COMMUNITY SERVICES NOW RECIEVING:
   VNA ____
   HOMEMAKER ____
   MENTAL HEALTH ____
   M.T.A. STEPSAVER/S.T.S. ____
   MEALS ON WHEELS ____
   OTHER ____

2. PRESENT LIVING SITUATION:

   Being relocated or no fault eviction ____________________

   Inappropriately placed- (Group Home- Nursing Home) ___________

   Resides independently ________________________________

   Sub-standard housing ________________________________

   Receiving subsidized rent ____________________________

   Housing does not meet physical needs requires barrier, free

   enviroment ____

INCOME & FIXED EXPENSES

INCOME: 1. Social Security $______________

2. Other ______________

EXPENSES: 1. Rent ______________

2. Utilities ______________

3. Food ______________

4. Medical Expenses ______________

5. Other ______________

HEALTH ATTITUDES:

1. Understands medical problems and is compliant with prescribed treatment.______________
2. Lacks understanding of problem, but makes effort to comply with prescribed treatment.______________
3. Lacks understanding and little evidence of compliance (does not take medication as prescribed and/or adhere to diet).______________

3. ACTIVITIES OF DAILY LIVING:
   - A. 1. Dresses without assistance and in appropriate manner buttons buttoned, shoes matched, etc.______
     - 2. Dresses without assistance, but usually forgets buttons or buttons them incorrectly, etc.______
     - 3. Needs assistance with dressing.______________
   - B. Bathing
     - 1. Bathes without assistance.______________
     - 2. Bathes with some assistance (help with back and/or feet getting into or out of tub)______________
     - 3. Cannot bath without assistance.______________
   - C. Transfer
     - 1. Gets into and out of bed or chair without assistance ______________
     - 2. Gets into or out of bed or chair with minimal assistance (someone holding chair or walker)______
     - 3. Needs lifting in transfer______________
   - D. Ambulation
     - 1. Ambulates without assistance______________
     - 2. Ambulates using cane or walker______________
     - 3. Ambulates only with wheelchair______________

4. INDEPENDENT ACTIVITIES OF DAILY LIVING:
   - A. Telephoning
     - 1. Uses telephone without assistance______________
     - 2. Uses telephone if someone dials number______________
     - 3. Is unable to use phone______________

B. Medications
  1. Takes prescribed medication at appropriate time in amounts prescribed.__________________
  2. Takes medication with some assistance (reminded that it is time for medication.____________
  3. Not responsible for taking own medication._______

C. Housekeeping
  1. Able to perform housekeeping tasks without assistance (vacumming, dusting, making bed, etc)._________
  2. Unable to perform some or all housekeeping tasks, but presently receiving assistance.__________
  3. Unable to perform some or all housekeeping tasks, not receiving assistance.__________________

D. Laundry
  1. Does laundry without assistance (including sheets, towels, etc.__________________________
  2. Needs assistance with laundry and is presently receiving this.________________________
  3. Needs assistance with laundry and is not receiving it.___________________________________

E. Meal Preparation
  1. Prepares adequate meals without assistance (meals do not consist primarily of canned soup, mild, bread, etc.).___________________________
  2. Unable to prepare meals without assistance. Someone to prepare meals for client.______________
  3. Unalble to prepare adequate meals with assistance and receives no assistance.________________

F. Traveling
  1. Travels from residence independently.__________
  2. Travels from residence with some limitations.____
  3. Must be accompanied when leaving residence_______

G. Shopping
  1. Does shopping without assistance._______________
  2. Shops with some assistance (transportation, someone to carry purchases, etc.).__________________
  3. Unable to shop because of either physical or mental limitations (limited mobility, poor concentration, or purchases are inappropriate to money available.________________________________

5. SOCIAL RELATIONSHIPS

A. Contact with relatives (not living with client)
  1. At least weekly________________________________
  2. Monthly____
  3. Less than 1 time per month.____________________

B. Contact with friends.
  1. At least weekly._______________________________
  2. Monthly____
  3. Less than 1 time per month______________________

C. Phone contacts with friends or relatives
  1. At least weekly_________________________________
  2. Monthly____
  3. Less than 1 time per month______________________

D. Communication
   1. Has someone with whom to discuss most things______
   2. Has someone with whom to discuss major problems___
   3. No one with whom client feels comfortable discussin concerns________

E. Activities/Socialization
   1. Regular activity outside the home (church clubs, etc)_________
   2. Sporadic activity outside the home_______
   3. Seldom participates in activities outside the home (Isolated)________

F. Other support systems family and/or Social Services
   1. Obtains appropriate service for independent living___
   2. Receives some services but needs not totally met_____
   3. Needed services not received___________

TOTAL SCORE ___________________

37 to 54	PRIORITY 1
19 to 36	PRIORITY 2
1 to 18	PRIORITY 3

Risk to tenants _______________
24 hr Supervision_______________
Will not conform to rules______
Other___________________________

IMPRESSION/RECOMMENDATIONS:

____
____
____
____
____
____
____
____
____
____
____
____

SIGNATURE________________________

PHA PUBLIC HOUSING AGENCY OF THE CITY OF SAINT PAUL
350 Gilbert Building • 413 Wacouta Street • Saint Paul, Minnesota 55101 • Phone (612) 298-5668

June 30, 1989

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Roybal,

Thank you for sending the briefing packet from the hearing on Housing for the Frail Elderly held before the Select Committee on Aging. We are vitally interested in all the issues surrounding this subject. I was pleased to have the opportunity to share the report our agency developed on the "Social Service Needs in Public Housing Hi-Rises". I hope that you will find some additional information useful.

From the time the PHA's sixteen hi-rises were built (from 1959 to 1976) until a few years ago, they have been occupied primarily by elderly persons over the age of 62 who are capable of living independently. Two recent but very distinct phenomena have altered this traditional population "mix" and the manner in which the PHA must manage its hi-rises. I am referring to the increasing numbers of "frail elderly" and younger handicapped persons applying for and being admitted to hi-rises. These two population groups are putting considerable pressure on PHAs to provide or arrange supportive services, and placing other demands on our staff's time.

However, since HUD views the PHA as a shelter provider only, social service funding for the special needs populations has generally been an "ineligible expense". Also, the existing public/private network of social service providers has not been completely aware of or successful in targeting resources to these new populations, resulting in service "gaps" and many residents at risk of losing their apartments because of multiple chronic problems.

The first special needs population we are concerned about is the frail elderly. Many residents originally housed when the PHA hi-rises opened have "aged in place" and are now in their 70's, 80's and 90's. Of the PHA's approximately 2,650 hi-rise residents, 1,051 are over age 75. The average age of all elderly residents is 75 in Saint Paul's Public Housing and reportedly 80 in Minneapolis' Public Housing.

At or about age 75, many people experience the onset of frailty, the reduction of physical or emotional capabilities and the loss of a social support system to the extent that the person may become unable to maintain a household without assistance from others. Functional and cognitive impairments often prevent residents from seeking, negotiating and utilizing a complicated social service system.

Hi-rise residents who become frail are at risk of nursing home placement or other institutionalized care because of their inability to handle finances, maintain their apartments or respond to health or social needs appropriately. While the public/private network of case management, crisis intervention, counseling, home health care, etc. is invaluable, it needs to be augmented by a federally funded Congregate Housing Services Program (CHSP) as has been demonstrated in Saint Paul and at a number of other PHAs over the last several years.

Nationally, only about 2,000 people are served by the federally funded CHSP program. An estimated 5,720 to 7,800 are eligible and in need of this program in Minnesota alone. The Saint Paul CHSP Program serves 46 people.

The CHSP Program offers two daily meals, housekeeping, personal care assistance and case management services to eligible residents in two PHA hi-rises. The goal of the program is to delay or prevent unnecessary institutionalization of residents by providing on-site services tailored to meet individual needs. We would like to see the program expanded to all PHA hi-rises in Saint Paul and made available beyond the "demonstration phase" to all PHAs experiencing this same problem.

The second problem has to do with the redefinition of "elderly" to include persons officially diagnosed as physically disabled or handicapped, or mobility restricted, or chronically mentally ill, or chemically dependent, or included in other defined special needs groups. A limited number of handicapped/disabled individuals (with appropriate supportive services) housed in a hi-rise primarily occupied by senior citizens is not disruptive to the seniors and may even benefit both groups. However, both the Minneapolis and Saint Paul PHAs have experienced increases in the number of handicapped/disabled individuals housed in their combined 58 hi-rises (7,750 units) and both find this population increasing on their hi-rise waiting list, while the number of seniors applying for hi-rise apartments is decreasing.

As Congress and HUD have expanded eligibility for "elderly housing" to include younger physically and mentally impaired persons, significant numbers of handicapped/disabled individuals were de-institutionalized and need affordable housing. At the same time seniors are enjoying numerous housing alternatives other than conventional public housing, including the popular Section 202 elderly housing program which offers newer, more attractive apartments at identical rents and income standards as conventional public housing.

Many handicapped/disabled residents lack necessary supportive services to ensure their ability to function and live independently, which can ultimately lead to disruptive behavior and dwelling lease violations. Again, the PHAs are unable to provide direct social services to this population and service gaps exist in the public/private network due to high case loads and funding limitations. However, HUD could and should give PHAs the authority and funding to develop local solutions to this problem.

The recent HUD occupancy handbook change that permits PHAs to enforce the "independent living" standard and to require social service agreements with prospective tenants is a step in the right direction. However, PHAs often must expend more staff time to screen impaired applicants, monitor their stay in public housing and work with community social service agencies and health professionals to keep necessary services in place. HUD has provided no additional funding to PHAs for these needs. And on a broader scale, the federal government should once again begin full funding of alternative housing, especially housing with supportive services, for handicapped/disabled people.

Thank you for the leadership your committee has taken in researching and supporting needed housing/service options to try to better meet the needs of low-income residents in subsidized housing.

Sincerely,

Jon M. Gutzman
Executive Director

Social Service Needs
in
Public Housing Hi-Rises

A Report by the Public Housing Agency of the City of Saint Paul

PHA

May, 1988

For More Information, Contact

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413 Wacouta Street
St. Paul, Minnesota 55101
(612) 298-4487

PHA
PUBLIC HOUSING AGENCY OF THE CITY OF SAINT PAUL
350 Gilbert Building • 413 Wacouta Street • Saint Paul, Minnesota 55101 • Phone (612) 298-5888

April, 1988

To Whom It May Concern:

The existence of a mature, community-based network of supportive services for the residents of Saint Paul's public housing hi-rises is one of the best working examples of the "public-private partnership" phrase we hear so much of in Minnesota. Over 30 organizations from non-profits, to governmental agencies, to private corporations, participate in this community response. Many have served the hi-rise population since 1959, the year the first hi-rise was completed in Saint Paul. And recently, the PHA was cited in a housing study as being among the top eight percent of PHAs in the nation that "possess" such a comprehensive array of supportive services.

However, because the PHA is funded by the federal government (U.S. Department of Housing and Urban Development) as a shelter provider only, the existence of this non-PHA service network has also become a necessity if we hope to plan for the entire well-being of the residents. Also, it is a shared view among our staff and the service providers that, in terms of age, functioning ability, and other measurable criteria, today's hi-rise population is less homogeneous than the hi-rise population of five to ten years ago, and, significantly, some of the "newer" hi-rise populations are underserved or unserved by the existing social service network.

It is in this context that the PHA undertook to survey the social service needs in today's public housing hi-rises. While certainly not an exhaustive review of the issue, we think the study presents a useful starting point for reviewing the needs, recognizing the providers, identifying gaps in services, and offering recommendations for change where appropriate. I am confident that our staff and the community will continue to respond positively to the challenges referenced in this report.

I would like to thank Dorothy Davey, PHA Director of Resident Services, and Erik-Paul Sallmen, Edie Pierce-Thomas, Elaine Anderson, Judy Dahlberg, Cheryl Hawley, Heidi Sandberg and Jill Leimer of her staff for their excellent research and preparation of this report.

Sincerely,

Jon M. Gutzman
Executive Director

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THE PUBLIC HOUSING AGENCY OF THE CITY OF SAINT PAUL
SOCIAL SERVICE NEEDS IN PUBLIC HOUSING HI-RISES

INTRODUCTION

It is the purpose of this paper to outline the responsibilities of the Public Housing Agency (PHA) as mandated by public law and to set forth the needs of the persons who live in public housing which cannot be met by the PHA.

The PHA is an independent agency created through action of the Minnesota State Legislature in accordance with the United States Housing Act of 1937. It is governed by a seven member Board of Commissioners (two of whom must, by law, be PHA residents) appointed by the Mayor with City Council concurrence. The Board of Commissioners sets PHA policy and oversees its operations in accordance with federal regulations promulgated by the United States Department of Housing and Urban Development (HUD).

The PHA receives its income from rents paid by residents (70%) and an annual federal subsidy received from HUD (30%). The PHA receives no City, County, State or other public funds.

The PHA owns and operates dwelling units which house approximately 10,000 people. It also administers the Section 8 Existing Housing Assistance Payments Program which subsidizes the rent of 2418 households. The PHA operates sixteen hi-rises located throughout the City of Saint Paul in which approximately 2700 elderly and disabled/handicapped residents are housed.

The mission of the PHA is to provide to as many eligible low-income families as possible the opportunity to live in safe, decent and sanitary housing and to provide such housing in an efficient and effective manner. The PHA is a housing provider. It is not a social service agency.

Public housing is not "housing of last resort". The PHA is expected to make a thorough evaluation of applicants to determine whether their admission to a hi-rise would be reasonably expected to have a detrimental effect on other residents or on the housing environment. All applicants must be evaluated to determine if they meet the following admissions criteria:

1. The head of household or spouse:
    a. is at least 62 years of age, or
    b. is disabled, or
    c. is handicapped, or
    d. qualifies as a single person for certain apartments in certain hi-rises, or
    e. qualifies as a non-elderly family with no minor dependents for certain hi-rises, and

2. whose annual income does not exceed the maximum income limits in effect at the time of admission, and

3. who meet other non-economic qualifications which include:
    a. a satisfactory rent and utility payment record,
    b. no record of disturbances of neighbors,
    c. no record of destruction of property,
    d. a satisfactory housekeeping record,
    e. no history of criminal acts which may adversely affect the health, safety or welfare of other PHA residents, and
    f. the ability to live independently.

HUD regulations mandate that the PHA admit only applicants who are able to manage a household and comply with the Dwelling Lease. To determine this, the PHA conducts a thorough assessment of an applicant's capabilities to live independently. In making such an assessment, the PHA considers, in addition to other factors, the applicant's social service needs and the availability of services to meet those needs. Before admission is granted, the PHA may require an agreement by a social service agency to provide support services to applicants who need special help in order to establish tenancy. Such a requirement can be incorporated into the lease, and the failure of the tenant or the social service agency to abide by the terms of the agreement can be grounds for termination of the lease.

Persons admitted to public housing may later be found to no longer possess the ability to maintain themselves and their homes in the manner expected of them. Without services which help residents to preserve their independence, these residents may be forced to seek other, more costly (to the public) assisted living arrangements. Some of the factors which made hi-rise residents eligible to live in public housing (low-income, age, handicap or disability) may contribute to their need for services. To a great extent, residents are expected to locate and coordinate services for themselves but many do not know how or are not capable of doing so.

The PHA does not have the funds or the staff available to provide direct social services needed by hi-rise residents. We are all too aware of the debilitating effect that budget cuts at all levels of government have had on agencies trying to provide needed services in the community. We too are trying to do more with less. Only two PHA Human Services Coordinators are available to help assess the needs of the residents and assist them in locating and receiving appropriate services. They also perform crisis intervention and follow through with outside agencies. One Manager, one Associate Manager and two Assistant Managers perform all the management functions for 14 hi-rise buildings. (Mt. Airy and Dunedin are served by the on-site staff.)

Managers often learn of residents' needs through routine housekeeping inspections, contractor reports, complaints from other residents, special or annual income reviews or rent delinquencies. Problems concerning social service needs are generally referred to one of the two PHA Human Services Coordinators.

The Human Services Coordinators receive the majority of their referrals from the Managers, Caretakers, family and neighbors. They also receive referrals from outside agencies involved with residents (i.e. a nurse from the "Mini Clinic"). In addition, residents contact the Human Services Coordinator directly for assistance.

A Resident Caretaker whose primary job is maintaining the physical structure and preparing vacant units for re-rental is assigned to each building. Caretakers learn of problems through day to day contact with residents while performing routine maintenance tasks and responding to emergency calls (i.e. when a resident pulls the call cord in the bathroom or fails to display an OK card). Caretakers refer, as appropriate, cases to the Managers and Human Services Coordinators for assistance.

In the following pages, we intend to describe the present hi-rise population, to identify their social service needs and to point out areas where those needs are and are not being met. We have also set forth recommendations for consideration and discussion in the months ahead. It should be understood that our recommendations are for the long term and we are fully aware that because of lack of resources in the community they may not be achieved in the near future.

As background to a discussion about the PHA hi-rise resident service needs and responses to those needs, some general demographic information may be useful.

The following statistics have been compiled by PHA staff from the PHA's computerized Public Housing Applicant System, Tenant Accounting System, Applicant and Tenant Files and Hi-rise Waiting List, as well as from census data and material provided by some of the community agencies providing services to hi-rise residents. The data are by no means exhaustive. PHA data collection and retrieval capabilities are not geared to research requirements. Nevertheless, what is provided may lend perspective to the issues.

TABLE 1

HI-RISE RESIDENT DEMOGRAPHICS
OCTOBER 31, 1987

	NUMBER	PERCENT-AGE
HI-RISE RESIDENT POPULATION (See Note 1, next page)	2,650	100.0
RESIDENTS BY AGE		
Under 62 (Note 2)	548	20.7
Near Elderly (55 to 61)	196	7.4
62 and Older	2,102	79.3
Young Elderly (62 to 69)	454	17.1
Mid Elderly (70 to 79)	896	33.8
Old Elderly (80+)	752	28.4
AVERAGE AGE OF ELDERLY RESIDENTS: (Note 3) 75		
"SINGLE PERSONS" (Note 4)	83	3.1
RESIDENTS BY HANDICAP/DISABILITY		
Total Handicapped/Disabled	801	30.2
Handicapped/Disabled-Under 62	465	17.5
Handicapped/Disabled-62 and Older	336	12.7
Physically Handicapped-Mobility Restricted (Note 5)	298	11.2
Chronically Mentally Ill (Note 6)	252	9.5
Chemically Dependent (Note 7)	176	6.6
Hearing Impaired (Note 8)	73	2.8
Sight Impaired (Note 9)	49	1.8
Mentally Retarded	44	1.7
Other Disabilities (Note 10)	33	1.2
Respiratory Disease (Note 11)	28	1.0
Coronary Disease (Note 11)	23	.9

AVERAGE ANNUAL INCOME OF RESIDENTS: $6,411, which is approximately 24 percent of the median income for the Twin Cities SMSA.

NOTES TO TABLE 1, HI-RISE RESIDENT DEMOGRAPHICS:

1. The hi-rise resident population figure includes all residents who are eligible by income, age, handicap or disability. Residents who are eligible under the PHA's Single Persons Program are also counted. (See Note 4., below.) Resident Caretakers, their household members and non-elderly, non-handicapped/disabled members of households headed by program-eligible persons are not included in the adjusted total.

2. The age of 62 is significant because it is the age at which a person is deemed to be "Elderly" by HUD's definition. (HUD also places handicapped and disabled persons in the "Elderly" category. Throughout this paper, however, we use "Elderly" to describe only persons who are 62 or older.)

3. At or about the age of 75 many people may experience the onset of frailty, according to Department of Health, Education and Welfare Publication #OHDS-79-20959, "Public Policy and the Frail Elderly". In the publication, frailty is defined as "... the reduction of physical and emotional capabilities and loss of a social support system to the extent that the individual becomes unable to maintain a household or social contacts without assistance from others."

   1,051 hi-rise residents are 75 years old or older.

4. The PHA is restricted to housing no more than 90 Single Persons at any given time. Single Person residents are low-income, but do not meet age or handicap/disability eligibility criteria. Single Persons are housed, generally, in efficiency apartments (no separate bedroom) because the PHA has difficulty in renting these apartments to the Elderly, Handicapped or Disabled.

5. Included in this category are those residents who are officially diagnosed as physically disabled or handicapped and mobility restricted and those residents who are observed by PHA staff to have significant mobility problems due to, for example, frailty caused by advanced age.

6. Included in this category are those residents who are diagnosed as being chronically mentally ill. It is highly significant that since the fall of 1985, the number of mentally ill hi-rise residents has increased from 141 to 252. This is about an 80% increase in two years and represents 9.5% of the adjusted total hi-rise population. There likely are considerably more residents who suffer from some form of mental illness that, while being debilitating, has gone undiagnosed and untreated.

7. The majority of residents in this category are diagnosed as being alcoholic or have come to the attention of PHA staff because their use of alcohol has caused ongoing problems including disturbances, fighting, property damage, poor housekeeping and rent delinquency. Considerably more residents may be abusing alcohol but they have not caused readily noticeable problems for themselves or others. Estimates of chemical dependency in the general population range from a low of 3% to a high of 15%.

8. This category includes only those residents who have been diagnosed as having a profound hearing loss; i.e., it is one of the reasons why they are eligible for public housing. Not included are the many residents who have a slight to moderate hearing loss which may be diminishing their ability to interact with others.

9. Only residents with a profound visual impairment are included. Again, many more residents have a slight to moderate impairment with a corresponding

diminishment of ability to negotiate activities of daily living.

10. This category accounts for those handicap/disability types which each represent significantly less than 1% of the adjusted total hi-rise population. Examples of handicaps/disabilities included here are Lupus, Multiple Sclerosis, back injuries of various sorts, and Acquired Immune Deficiency Syndrome.

11. The respiratory disease and coronary disease categories include only those residents who were admitted to public housing due to the disability resulting from the disease. There certainly are many other residents who have respiratory or coronary problems.

TABLE 2

HI-RISE WAITING LIST DEMOGRAPHICS
OCTOBER 31, 1987

	NUMBER	PERCENTAGE
APPLICANTS ON WAITING LIST (Note 1)	210	100.0
APPLICANTS BY AGE		
Under 62 (Note 2)	85	40.5
Near Elderly (55 to 61)	18	8.6
62 and Older (Note 2)	125	59.5
Young Elderly (62 to 69)	49	23.3
Mid Elderly (70 to 79)	48	22.9
Old Elderly (80+)	28	13.3
AVERAGE AGE OF ELDERLY APPLICANTS (Note 3) 72		
APPLICANTS BY HANDICAP/DISABILITY		
Total Handicapped/Disabled (Note 4)	123	58.6
Handicapped/Disabled-Under 62	85	40.5
Handicapped/Disabled-62 and Older	38	18.1
Chronically Mentally Ill	41	19.5
Chemically Dependent	31	14.8
Other Disabilities	26	12.4
Mentally Retarded	7	3.3
Wheelchair Confined	7	3.3
Hearing Impaired	6	2.9
Sight Impaired	5	2.4

AVERAGE ANNUAL INCOME OF APPLICANTS (Note 5) $6,651, which is approximately 25 percent of the median income for the Twin Cities SMSA.

NOTES TO TABLE 2, HI-RISE WAITING LIST DEMOGRAPHICS

1. The total number of Applicants on the Waiting List represents those people who have applied and have been determined to be eligible by income only. When an Applicant's name nears the top of the waiting list, the process of assessing the Applicant's eligibility according to the PHA's non-economic eligibility criteria is completed (See Page 2, above). Depending on the outcome of the assessment, the Applicant may or may not be admitted.

   Single Person Applicants are not included in this Waiting List Total. As of October 31, 1987, there were a total of 146 Single Person Applicants.

2. While the ratio of Elderly residents compared to Non-elderly residents is about 4 to 1, the ratio of Elderly Applicants compared to Non-elderly Applicants is closer to 3 to 2. This points to a trend that started a few years ago and is, in large part, a result of Minnesota's efforts to deinstitutionalize mentally ill persons and others with significant impairments. It also indicates the need to increase services to this younger disabled population.

3. Of the Elderly Applicants who are housed in the near future, approximately half will reach the age of 75 within three years. As stated earlier, at or about the age of 75, many people experience the onset of frailty.

4. The percentage of Handicapped/Disabled Applicants on the Waiting List (58.6) is almost double the percentage of Handicapped/Disabled Hi-rise Residents (30.2), again pointing to the increasing demand for decent, affordable housing by this segment of the community population. However, Handicapped/Disabled Applicants must meet the same "independent living" and other non-economic eligibility criteria as Elderly Applicants. (Applicants

who are denied admission are informed of their right to contest the PHA's decision in an informal hearing before a committee comprised of three residents and two PHA staff members. The burden of proof rests upon the PHA.)

5. It is important to point out that the average annual income of applicants ($6,651) and residents ($6,411) is extremely low especially when compared with the PHA's Annual Income Limit, which for one person is $21,300, which represents 80% of the median income for the Twin Cities Metropolitan Area. (The income limits usually are adjusted annually, upon notification from HUD.) These average income figures are only slightly above the federally-defined "poverty line," of $5,500 for a 1-person household (1987).

LANGUAGE AND CULTURAL DIVERSITY

A wide variety of languages and cultures are represented in the hi-rise population. The residents in these groups have a language other than English as their primary language, or, in the case of some, do not speak English at all. PHA staff generally has had little difficulty in obtaining interpreter/translator services when necessary. Resources in this area include the International Institute, Jewish Family Service and the various cultural associations found in the Twin Cities and the PHA's own interpreters for Spanish and some Southeast Asian languages.

Groups represented include:

Russian
Spanish
Lebanese
Ethiopian
Hmong
Chinese
Korean

Vietnamese
Laotian
Cambodian
Iranian
Filipino
Egyptian

SOCIAL SERVICES IN HI-RISES

I. INFORMATION AND REFERRAL, CASE MANAGEMENT AND COUNSELING

A. NEED:

Some older frail residents and younger disabled residents are at risk of losing their apartments because of multiple chronic problems. Functional and cognitive impairments often prevent residents from seeking, negotiating and utilizing a complicated social service system. Frequently these impairments translate into the inability to handle finances, maintain apartments or respond to health and social needs appropriately. The availability of PHA staff and staff from other agencies to help residents make the connections with appropriate social services has decreased in the last few years while service needs have increased. Linkage with suitable community resources can often prevent small problems from becoming large and overwhelming. Because of frailty, physical and/or mental disabilities, many residents are unable to utilize case management services unless they are provided on-site.

Case management can circumvent the need for institutional placement for an estimated 5-10% of the hi-rise population. With fragmented community services from multiple providers utilizing complex payment functions, coupled with inadequate resources, the residents' needs are frequently unmet. Case management encompasses screening, assessment, care planning, monitoring and advocacy. It is critically needed. Successful intervention with residents who have fluctuating physical and mental health conditions can be dependent upon regular monitoring so that corresponding modifications of services can be made.

Counseling is necessary for a number of residents who are unable to resolve or to cope with stresses such as loss of loved ones, adversary relationships or financial problems.

B. PROVIDERS:

1. First Call for Help
2. Family Service of Greater St. Paul (on-site)
3. Catholic Charities (on-site)
4. Jewish Family Service (on-site)
5. Ramsey County Adult Services (on-site)
6. Ramsey County Mental Health (off-site)
7. Wilder Adult Day Care (on and off site)
8. Sharing Life in the Community (SLIC) (on and off site)
9. Youth Emergency Services/Nighttime Emergency Outreach Network (YES/NEON)

The coordinating team, consisting of PHA staff and key community providers, meet on a regular basis to identify client needs and develop service plans.

C. GAPS:

1. Case management services for mentally ill residents are extremely limited. In most cases, a continuum of care is unavailable or does not exist to the extent that it is needed by many mentally ill and mentally retarded residents.

2. Agencies such as Family Service of Greater St. Paul, Jewish Family Service and Catholic Charities provide on-site case management to the elderly but because of lack of resources do not serve younger residents.

3. Many agencies have long waiting lists and cannot see residents when services are needed.

4. Due to funding cuts over the past 10 years, on-site case management services in the hi-rises are available only to a limited number of residents.

5. On-site assistance to help residents with the paper work related to programs such as Medical Assistance, Supplemental Security Income, Veterans Administration benefits and housekeeping services is extremely limited or unavailable.

D. RECOMMENDATIONS:

1. That on-site case management services and a comprehensive continuum of care be made available to mentally ill residents. (It is hoped that the Minnesota Mental Health Act which mandates counties to provide case management services to the mentally ill will alleviate part of this need.)

2. That on-site case management and counseling services be made available to residents under 60 years of age.

3. While the quality of currently available case management services for the elderly is high, these services need to be made available to more residents.

4. That on-site assistance be made available to residents to complete forms for various services including Medical Assistance, Veterans Administration benefits and Supplemental Security Income.

II. HOMEMAKER/CHORE SERVICES

DEFINITIONS:

Chore service: One-time inside and outside heavy duty cleaning including wall and window washing, painting, etc.

Housekeeping services: Regularly scheduled housekeeping maintenance.

Homemaker services: Household management activities such as nutritional care, personal care, social and emotional support, home safety practices and housekeeping needs.

A. NEED:

The PHA is required by HUD to inspect apartments periodically to ensure that they meet minimum housekeeping standards. This requirement helps to ensure a safe, sanitary and decent housing environment.

Many of our residents, for reasons which may include frailty, physical or mental disability, are not able to meet the housekeeping standards. Residents who are unable to adequately maintain their apartments are not able to remain in public housing.

While some residents needing assistance receive help from their families or friends, many do not have this assistance available and rely on community services to meet their need.

B. PROVIDERS:

The Ramsey County Community Human Services Purchase of Service Unit provides housekeeping/homemaker services through contracted vendors at no cost to eligible clients.

The Ramsey County Community Human Services Alternative Care Program provides homemaker services through contracted vendors at no cost or on a sliding fee basis depending on client eligibility.

Two private non-profit agencies, the Amherst H. Wilder Foundation and Sister Care, provide chore/homemaker services with fees based on income only or income and assets.

For-profit agencies offer services at market rate.

C. GAPS:

1. 50% of the hi-rise residents are not eligible for Title XX housekeeping and homemaking services because their assets exceed a $1,500 asset ceiling.

2. The Amherst H. Wilder Foundation Home Care Services provides regular weekly or bi-monthly homemaker/housekeeping service to elderly in hi-rises within Wilder's geographical service area which includes all except Dunedin, Cleveland, Montreal, Seal and Iowa Hi-rises. Waiting lists sometimes delay initiation of service.

3. The Sister Care Program while successful, is still a small program and is unable to accept new clients at this time.

4. The non-profit agencies that offer sliding fee scales provide services only to hi-rises in some areas of the city.

5. Service through for-profit agencies is expensive and only a few residents can afford it.

6. Most vendors contracting with Ramsey County Community Human Services limit the services to "light housekeeping". These vendors do not provide the heavier cleaning which, if not done, jeopardizes residents' eligibility for continued occupancy in public housing (wall washing, window washing, and thorough cleaning of appliances).

7. Communication among case managers, Public Health Nurses and PHA staff and the housekeeping providers is hampered by the fact that many different Title XX vendors may be serving clients in any one building.

8. The quality of cleaning services is sometimes unsatisfactory. In some cases, workers do not show up for their assignments and clients go for a long time without service.

D. RECOMMENDATIONS:

1. That the Ramsey County Community Human Services raise Title XX asset limitations to serve a wider range of low income clients and implement a sliding fee scale for all persons receiving services or implement a sliding fee scale for those above the $1,500 asset ceiling.

2. That the Ramsey County Community Human Services Title XX clients receive the heavy duty cleaning help needed to meet the PHA's housekeeping standards.

3. That Ramsey County Community Human Services continue efforts to standardize and monitor and improve Title XX vendors' service.

4. That each hi-rise be served by no more than one Title XX housekeeping vendor. This would enhance communication between the housekeepers, case

managers, and PHA staff and would make training and monitoring more efficient. It would eliminate unnecessary travel and the present two-hour minimum service requirement.

5. That chore/homemaker services be expanded to meet the needs of residents in hi-rises in all areas of the city.

6. That funding sources such as United Way expand funding to non-profit agencies for the provision of services on a sliding fee scale basis.

III. NUTRITION

A. NEED:

Good nutrition is a vital element of physical and mental well-being. Our experience has shown that when nutritional needs are not met, physical and mental deterioration frequently follow. Many PHA residents are unable or un-motivated to prepare adequate meals for themselves. This may be due to frailty, physical disability, mental disability, depression or appetite loss. The need for assistance with meals may be long or short-term.

B. PROVIDERS:

Several home delivered meals programs provide hot noon meals Mondays through Fridays.

The Ramsey Action Programs (RAP) Senior Nutrition Project operates the Congregate Dining Program at eight PHA hi-rises. The program provides an opportunity for socialization. In addition two meals a day, seven days a week are provided for the Congregate Housing Services Program at Ravoux and Valley Hi-rise and for the Amherst H. Wilder Foundation's Assisted Living Program participants at the Ravoux Hi-rise.

C. GAPS:

1. The home delivered meal programs do not provide meals on weekends and holidays. The Congregate Dining Program provides a brown bag lunch for holidays but not for weekends.

2. The Congregate Dining Program is available in only eight PHA hi-rises.

D. RECOMMENDATIONS:

1. That the RAP Senior Nutrition Project provide meals on weekends.

2. That the home delivered meal programs be available on weekends and holidays.

3. That the Congregate Dining Program be expanded to serve more PHA hi-rises.

IV. MEDICAL/HOME HEALTH AID/PUBLIC HEALTH

A. NEED:

Many of the PHA's residents are frail, or have physical or mental illnesses or disabilities. They need health services such as health assessments, health supervision, health education, assistance with managing long-term illness (both physical and mental), post-hospital care, monitoring of medications and foot care. Many PHA residents are unable to go off-site to receive these services. In addition, some of our more frail or disabled residents require assistance with personal care, such as bathing and hair care.

B. PROVIDERS:

Ramsey County Public Health Nursing Service provides all the above services for a sliding fee. Medicare, Medical Assistance (Medicaid), Alternative Care funds and health insurance may cover some services. Under the quality assurance supervision of the Ramsey County Public Health Service, two Block Nurse programs, the St. Anthony Park Block Nurse Program and the Highland Block Nurse Program, also provides these services in two PHA Hi-rises for a sliding fee. A third Block Nurse Program, the North End Block Nurse Program, is being developed and will provide services to one additional PHA hi-rise.

Private home health care agencies, such as Upjohn Health Care Services and Integrated Home Care, also provide the above services, usually after a resident is discharged from a hospital. They charge full fee for service but Medicare, Medical Assistance (Medicaid) or Alternative Care funds may be used to cover all or part of the cost.

"Mini-Clinics" are located in most PHA hi-rises.

1. The St. Paul Division of Public Health operates monthly clinics at the following hi-rises:

    899 S. Cleveland
    727 Front
    325 Laurel
    1743 E. Iowa

    The registered nurses who staff the clinics check blood pressure, offer some health teaching through the distribution of brochures, refer to doctors or a nutritionists as needed, do weight checks, gives flu shots and review medications. On occasion, Vitamin B-12 shots are given by the clinic nurse.

2. Ramsey County Public Health Nursing Service operates clinics in the following hi-rises:*

    554 W. Central (2x/month)
    777 N. Hamline (2x/month)
    280 Ravoux (2x/month)
    200 E. Arch (1x/month)

    These clinics offer blood pressure screening. Referrals are made to the Ramsey County Public Health nurses if more than blood pressure screening is needed. In the past, these clinics were staffed by a geriatric nurse practitioner and the services were much more extensive.

*Ramsey County Public Health Nursing Service recently discontinued clinics at 261 E. Univerity and 10 W. Exchange. Future resumption of these clinics is uncertain.

3. Family Physicians Health Center operates a clinic at 1000 Edgerton two half days a week. The clinic is staffed by a nurse and two physicians. Services offered include physicals, EKGs, PAP smears and flu shots. Blood and urine samples are taken at the Edgerton clinic and sent to the Family Physicians Health Center for analysis. Fees are covered by the clinic participants' insurance, Medical Assistance (Medicaid) or Medicare. Costs not covered by insurance are waived or individual payment plans are arranged. Residents may see physicians by appointment and walk-ins are seen as time permits.

4. The University of Minnesota Hospital operates a clinic at 825 Seal one morning a week. Services offered include blood pressure screening, medication review, health promotion education and referral to the resident's doctor. As an added feature, the nurse does home visits upon request.

5. The Hazel Park Family Medical Clinic operates a clinic at 1300 Wilson twice a month. Most of the clinic participants are patients of the Hazel Park Family Medical Clinic. The clinic is staffed by a specially trained lab worker who takes blood pressures. This is the only service offered.

6. The St. Paul Urban Indian Health Board operates a clinic at 545 Wabasha once a month. The clinic is staffed by a specially trained nursing assistant who takes blood pressures. This is the only service offered.

7. The West Side Health Center operates a clinic twice a month at 469 Ada. A physician and a registered nurse staff the clinic. They do physicals, PAP smears, blood pressures, weight checks and flu shots. They also

draw blood and take urine samples for lab analysis at the West Side Health Center. The clinic staff does home visits on clinic days.

C. GAPS:

1. Private home health care agencies usually find it necessary to discontinue services when Medicare benefits stop and often do not refer clients requiring essential assistance to other on-going services or notify a referring agency who can make such a referral on the client's behalf.

2. Ramsey County Public Health Nursing Service has decreased the frequency and scope of their clinic services. (See footnote on Page 24.) In some cases, Ramsey County Public Health nurses have been replaced with Licensed Practical Nurses. As a consequence, health assessments and home visits are no longer provided.

3. Most of these clinics do not offer health assessment, home visits, physician referrals and follow-up, medication reviews, and flu shots. Nor do they provide enough clinic hours.

4. The Block Nurse programs are restricted to serving residents 65 years of age or older and are currently providing services in only two PHA hi-rise neighborhoods.

5. Some clinic nurses do not attend monthly coordinating meetings at which time cases are discussed and reviewed and appropriate referrals are made.

6. Many residents who belong to health care plans such as SHARE have been

denied needed services that are available to elderly in other plans, such as Ramsey Care, Group Health, Seniors Plus and the MOD (Outpatient) Clinic at United Hospital.

D. RECOMMENDATIONS:

1. That private home health care agencies inform PHA staff when they discontinue services to PHA residents.

2. That health maintenance organizations provide optional coverage for home health care services that are not reimbursable by Medicare.

3. That the Ramsey County Public Health Nursing Service resume operating clinics at 261 E. University and 10 W. Exchange and that the St. Paul Division of Public Health continue at the four sites listed in B.1. above.

4. That Ramsey County Public Health Nursing Service, the St. Paul Division of Public Health, the Hazel Park Family Medical Clinic and the St. Paul Indian Health Board increase the frequency and scope of their clinics. These clinics should be staffed by public health nurses or geriatric nurse practioners, as was done in some clinics in the past.

5. That more private clinics provide on-site clinical services as a community service, using the Edgerton Hi-rise Clinic as a model.

6. That Ramsey County Public Health Nursing Service expand the Block Nurse program to provide service in additional PHA hi-rise neighborhoods.

7. That health care plans, such as SHARE, provide the same services to their clients that other seniors on Medicare or Medical Assistance (Medicaid) can obtain.

V. CRISIS INTERVENTION

A. NEED:

Because of the population the PHA serves, crises occur on a regular basis. Types of crises include:

Medical
Chemical Dependency
Psychotic episodes
Suicides
Physical, emotional, sexual abuse
Neglect
Disturbances

Because these crises occur on PHA property and often involve other residents, PHA staff is on the scene early to assess the need and attempt to get community resources to assist the resident(s). At times these services are not readily available on-site.

B. PROVIDERS:

The following provide on-site crisis intervention:

St. Paul Division of Public Health, Ramsey County Public Health Nursing Service, Senior Chemical Dependency Program, Police, Paramedics and Family Service of Greater St. Paul.

C. GAPS:

1. Agencies that provide case management are often unavailable to intervene quickly in their client's crisis.

2. Generally speaking, agencies do not want to take on a new client in a crisis.

3. Because of Diagnostic Review Guidelines (DRGs), hospitals are discharging patients more quickly and necessary follow-up services may not have been arranged.

4. Some home health care agencies stop serving clients when Medicare funds run out. These clients may not be referred for other appropriate services. This can result in medical emergencies.

5. Staff in most agencies are available only during regular daytime working hours.

D. RECOMMENDATIONS:

1. That agencies provide on-site crisis intervention for their current clients.

2. That agencies, such as SLIC, provide on-site crisis intervention services for former clients and do follow-up if appropriate.

3. That agencies with expertise in mental illness take on new clients in crisis.

VI. CHEMICAL DEPENDENCY

A. NEED:

Residents who misuse alcohol or other chemicals often have problems complying with their dwelling lease. These problems may include neighbor disturbances, jeopardizing the safety of themselves or others, property damage and/or poor housekeeping. The chemically dependent person often does not recognize the problem. Therefore, on-site intervention is necessary.

B. PROVIDERS:

The Senior Chemical Dependency Program and Catholic Charities do on-site intervention and counseling for public housing residents.

C. GAPS:

1. There is very limited on-site intervention and counseling for the younger handicapped and disabled residents.

D. RECOMMENDATIONS:

1. That agencies other than Senior Chemical Dependency Program and Catholic Charities which have chemical dependency programs do on-site interventions with their clients.

2. That agencies with chemical dependency programs accept referrals of younger handicapped and disabled residents that need immediate on-site intervention.

VII. OTHER SERVICES

There are many services that, while not so basic as those heretofore addressed, are essential to a satisfactory quality of life for hi-rise residents. The list of such services is a long one but must include the following:

A. TRANSPORTATION:

1. NEED:

Many hi-rise residents, for reasons including frailty and physical and/or mental disability, are unable to ride buses. Most cannot afford cab fare. Family and friends provide necessary transportation to medical appointments and shopping for some residents. Others must rely on community services.

2. PROVIDERS:

A variety of organizations provide transportation for seniors and/or the handicapped to medical appointments for a donation or a reasonable fee. These organizations include the Red Cross, Amherst H. Wilder Foundation, Ramsey Action Programs, Spanish Speaking Seniors, Ramsey County Community Human Services, the Trinity Foundation and Metro Mobility. A variety of grocery stores provide free bus transportation for shopping. K-Mart now offers bus services to their stores on a monthly basis. The Red Cross offers coordinated transportation services.

3. GAPS:

There are few transportation services available for recreational activities. There are limited resources for transportation for shopping other than grocery shopping. Transportation is generally not available with less than a 24 hour request to the transportation providers.

4. **RECOMMENDATIONS:**

That more stores and shopping malls provide buses to and from the hi-rises. That transportation on short notice be made available for acute non-emergency medical situations.

B. LEGAL:

1. NEED:

Occasionally, residents need advice and/or representation in non-criminal legal matters, such as wills and government benefits. Most of the residents are unable to afford the services of an attorney. Many are unable to seek out legal resources. They need on-site legal advice and information available on a regular basis.

2. PROVIDERS:

Senior Law Project - provides free advice and representations for persons over 60.

Southern Minnesota Regional Legal Services - provides free advice and representation for low-income persons.

Legal Advocates For the Blind - provides legal representation for blind or visually handicapped persons whose legal problems are related to their visual handicap.

Minnesota Civil Liberties Union - provides free legal counsel for cases that involve claims of civil liberties violations.

Centro-Legal - provides legal services on a sliding fee basis to low-income bilingual (Spanish/English) persons.

Minnesota Mental Health Law Project - provides advice and representation for the mentally ill.

3. GAPS:

There are no on-site legal services available on a regular basis.

4. RECOMMENDATIONS:

That providers make a legal professional available to hold regular office hours in each hi-rise on a periodic basis.

C. RECREATION:

1. NEED:

Socialization is important in maintaining one's health. Recreation encourages socialization, which can reduce isolation and depression. It is important to have recreational activities on-site, as it helps build a sense of "community". Many residents are unable to participate in recreational activities located outside the hi-rise.

2. PROVIDERS:

Most recreational activities in the hi-rises are organized by the Resident Councils.

There are off-site community recreational activities available, through local community programs such as churches, senior centers and the St. Paul Special Programs section of the St. Paul Division of Parks and Recreation.

3. GAPS:

Some hi-rises have very active Resident Councils and others do not. For these hi-rises which do not or cannot organize activities for themselves, there are few resources available to assist Resident Councils in developing and coordinating programs.

4. RECOMMENDATIONS:

That the Adopt-A-Hi-rise Program be expanded to include all 16 PHA hi-rises.

That local community organizations provide more outreach and/or direct recreational activities in the hi-rises as needed.

That the possibility of locating a multi-purpose senior center in or adjacent to a hi-rise be investigated.

VIII. SPECIAL HOUSING/SUPPORTIVE SERVICES PROGRAMS IN THE HI-RISES

The profile of the hi-rise resident population appears to have changed over the past ten years from one which was predominantly age 62 and over to one where a significant portion of the population is made up of younger handicapped and disabled persons. In addition, the senior citizen population is apparently older and more frail than previously.

It appears that these trends will continue in the foreseeable future. As noted earlier in this report, the average age of persons age 62 and over on the PHA waiting list for hi-rises is 72. In addition, 40.5% of the waiting list is younger, handicapped/disabled individuals. If these people are to be admitted to the hi-rises and are to continue in occupancy increased services will be needed.

In recent years, special programs have been developed to assist hi-rise residents who are not completely capable of independent living:

A. The Congregate Housing Services Program (CHSP), funded by Title IV of the Housing and Community Development Act of 1978, is administered by the PHA. The program provides service for up to 46 residents at any given time, and has served 150 participants throughout the past five years. The program offers two daily meals, housekeeping, personal care assistance and case management services to eligible residents at the Ravoux and Valley Hi-rises. The goal of the program is to delay or prevent unnecessary institutionalization of participants by providing of an on-site package of services tailored to meet individual needs. Participants pay for services on a sliding fee scale. The program is made possible through the pooling of a number of resources including HUD CHSP subsidies, Title III-B Ramsey Action Program Senior Nutrition dollars, Ramsey County Community Human Service Title XX Funds and Alternative Care funds. Program guidance is provided by a Professional Assessment Committee comprised of members from public and private agencies, along with PHA resident input.

B. The Assisted Living Program (ALP), administered by the Amherst H. Wilder Foundation, offers three daily meals, monitoring of the self administration of medications, 24 hour emergency response assistance, housekeeping, personal care assistance, case management and adult day care services for up to 30 elderly participants at the Ravoux Hi-rise. Participants who can handle their basic activities of daily living but who require a package of non-medical services to enable them to remain in their own apartments can benefit from this licensed board and lodging program. A community-wide committee designed the ALP to fill a gap that existed between the level of services available in the CHSP and nursing care facilities. The ALP also utilizes the Professional Assessment Committee to assess program applicants.

C. The Saint Paul Ramsey Medical Center Commission administers a program at Central Hi-rise for direct support services for up to 10 hearing impaired individuals who also suffer from mental or emotional disabilities. A full time project director and 2 part-time case workers provide the services which permit the participants to live successfully in their own apartments.

These programs, of course, affect a relatively small number of the hi-rise residents but the PHA considers them significant. We hope to see other innovative programs developed in the future, and established programs expanded to serve other sites.

CONCLUSION

The St. Paul community has a long standing tradition of working cooperatively to meet the needs of residents of the community, as is attested to by the many valuable services currently being provided to public housing residents by St. Paul and Ramsey County service agencies. The staff of the Public Housing Agency of the City of Saint Paul salute the agencies and organizations within the City and County who provide these valuable services to PHA residents. It is our hope that the community planners and the social service providers will endeavor to fulfill the service needs identified in this paper. The PHA can and will continue to provide decent housing for low income individuals and families but it requires the professional skills of many other agencies to help those residents who cannot live independently become and remain eligible for public housing.

HI-RISE LOCATION	PROJECT NO.	# OF UNITS	Congregate Dining	Grocery Bus	Milk Delivery	"Mini-Clinic"	12-Step Group	Active OK Card System	Barber/Beauty Salon	Adopt-A-Hi-Rise	CHSP (10)	ALP (11)	Program for the Hearing Impaired	Accessible Space (12)	Religious Services	Parcel Delivery	Senior Center Within Walking Distance	Craft Group	Exercise Group	Podiatry Service	Block Nurse Program	Food Stamp ReCertification Monthly
200 E. Arch St.	1-3	175	X[1]	X	X	X		X		X					X	X						X
554 W. Central Ave.	1-5	144		X		X		X	X				X		X[3]	X	X[6]			X		X
261 E. University Ave.	1-6	196	X	X	X	X		X			X				X	X				X		X
325 Laurel Ave.	1-7	139		X	X	X		X	X						X[3]	X				X		X
469 Ada St.	1-9	145	X	X		X	X	X	X						X	X	X	X		X		X
899 S. Cleveland Ave.	1-11	144		X	X	X		X	X						X	X			X	X	X	X
1743 E. Iowa Ave.	1-13	148			X	X		X							X[4]	X				X		X
1300 Wilson Ave.	1-14	187		X	X	X		X							X	X			X	X		X
727 Front Ave.	1-15	151	X	X	X	X		X	X	X					X	X		X[7]		X	X[9]	X
280 Ravoux St.	1-16	220	X	X	X	X		X	X	X	X	X			X	X		X	X[8]	X		X
545 N. Wabasha St.	1-17	75	X					X	X	X					[5]	X	X					X
1085 Montreal Ave.	1-18	187		X	X			X	X	X					X	X				X		X
10 W. Exchange St.	1-19	194	X	X	X	X	X	X							X	X	X			X		X
1000 Edgerton St.	1-24	220	X[2]	X	X	X	X	X	X						X	X						X
777 N. Hamline Ave.	1-26	186	X	X	X	X		X	X						X	X		X	X	X		X
825 Seal St.	1-27	144	X	X	X	X		X	X						X	X	X		X	X	X	X

NOTES:

1) Transportation is provided to Valley Hi-rise for Congregate Dining.

2) No Congregate Dining but the Resident Council cooks a meal twice a week for the entire Hi-rise.

3) Bible study group only.

4) In winter only

5) Church one block away.

6) Martin Luther King Center provides transportation to their center.

7) In fall only in preparation for their Bazaar.

8) Physical Therapy for the ALP only.

9) Is not yet in existence but will be available in near future.

10) Congregate Housing Services Program.

11) Assisted Living Program.

12) A proposed program for brain injured individuals to be placed in one of our hi-rises - location still unknown.

NEW YORK STATE OFFICE FOR THE AGING
Mario M. Cuomo, Governor 2 Empire State Plaza, Albany, NY 12223-0001 Jane G. Gould, Director

June 14, 1989

JUN 3

Congressman Edward R. Roybal
Chairman
Select Committee on Aging
U.S. House of Representatives
300 New Jersey Avenue, SE
Room 712
Washington, DC 20515

Dear Congressman Roybal:

I was pleased to read in the May 22nd issue of the Select Committee on Aging's NEWS Bulletin that you have introduced H.R. 2376, the Comprehensive Housing Bill which addresses the needs of the frail elderly.

As you know, New York has the second largest number of older persons in the nation. We are actively pursuing strategies for providing appropriate housing alternatives for our older population, and we are particularly interested in options that include the provision or availability of supportive assistance. One of these alternatives is Congregate Housing, the integration of housing and services.

Research by the New York State Office for the Aging has shown that the concept of integrating housing and services for older persons has expanded over the past 10 years to include a number of successful models. A particularly successful version of the "Congregate Concept" is the Senior Resident Advisor Program which operates in approximately 16 of the New York City Public Housing Authority's multi-unit apartment buildings and which has been replicated by other housing sponsors. In this program, an on-site paraprofessional is employed for each building to provide counselling, information and referral, and the facilitation of residents' access to community services. The cost of these staff persons in the Senior Resident Advisor Program is supported through a grant from the City of New York.

The major barrier in replicating various versions of this program is finding financial support to cover the cost of the services coordinator. Your bill's provisions that would allow the services coordinator cost and a portion of services to be considered eligible management expenses, and that would amend cost containment

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requirements to allow more creative planning for service provision, are excellent strategies for moving forward in the search for creative ways of cost-effectively addressing the growing need for Congregate Housing/Services.

I am particularly interested in the development of the congregate concept of integrating housing and services as a housing option because this concept is capable of flexibly providing a range of services and assistance to residents, thereby meeting the different levels of need characteristic of the resident populations of senior housing buildings. This concept is also beneficial in that it responds appropriately to the overwhelming preference of older persons to age in place and to continue living in the privacy of their own apartments.

As the number of frail older persons continues to increase and State and federal policies stress cost containment in the provision of long term care, I am pleased to see your leadership in promoting the understanding that appropriate housing for older persons can no longer be seen as separate from services but that housing with services is a crucial component of the long term care system.

Sincerely,

Jane G. Gould

Jane G. Gould
Director

cc: Dr. David Axelrod, Commissioner
NYS Department of Health

Mr. Richard Higgins, Commissioner
NYS Division of Housing and Community Renewal

Mr. Cesar Perales, Commissioner
NYS Department of Social Services

Enclosure: A Review of Congregate Housing in the United States

A Review of Congregate Housing in the United States

This report provides background information on the status of
the congregate housing/services concept for older adults in the United States,
including a comparison of five state-sponsored congregate services programs.

New York State Office For The Aging
Mario M. Cuomo, Governor *Eugene S. Callender, Director*
Division of Program Development and Evaluation

Vera Prosper
1987

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Executive Summary

Theoretically, any shared living arrangement among a group of unrelated persons of any age operating as an economic unit is a congregate housing arrangement. Currently, however, the term "congregate housing" is used by policy makers to specify a multi-unit or shared housing environment for the elderly which integrates private apartment living with supportive services. The term connotes a philosophy purporting that appropriate shelter is only one of a number of services required by older adults (those aged 60 and over) to maintain themselves as independently as possible in their later years; that, in designing appropriate living alternatives for older adults, housing and supportive services should be considered as one rather than as two disparate categories of needs. Usually, these supportive services are congregate meals, housekeeping, transportation, 24-hour emergency response, and personal care (assistance with ADLs* and IADLs*).

The following report was developed to provide policy analysts and program planners with a description and understanding of congregate housing in the United States. The name "congregate housing" is used indiscriminately by developers of many housing/services models, and congregate programs are called by a variety of names. Therefore, this report will use the term "congregate housing/services concept" to include any non-institutionalized, multi-unit housing project for the elderly that includes private residential space and the provision or availability of an optional services component that has been developed or coordinated specifically for the residents of that housing project.

While the concept of congregate living is over 2,000 years old, governmental involvement in promoting the concept as a means to contain the costs of institutional care is only about 20 years old. Through the Department of Housing and Urban Development, the federal government legislatively promoted the construction of congregate housing in 1970 and supplemented that effort with the Congregate Housing Services Program in 1978 (currently operating in approximately 62 sites across the country). Through a 1979 Memorandum of Understanding between the federal Administration On Aging and the federal Farmers Home Administration, a demonstration Congregate Housing program was implemented in ten sites across the country, with the Farmers Home Administration supporting construction loans and the Administration On Aging providing funds for supporting the services component. The majority of state-sponsored demonstration congregate programs were implemented between 1976 and 1981. While the fledgling state-sponsored congregate effort has expanded steadily, the private congregate housing industry has flourished across the country in response to a rapidly growing market demand for this housing alternative.

Four situations merged to persuade state governments to develop congregate programs, as well as other community-based service programs, to meet the needs of a growing older adult population:

1. Specialized housing projects built in the 1960's and 1970's for low income, "well elderly" found that their resident populations did not turn over but, rather, aged-in-place. Managers found it was difficult to force out an aged resident who needed only assistance in some daily activities in order to remain in the housing project.

---

* ADL (Activities of Daily Living): bathing, toileting, grooming, dressing, transferring, mobility, eating.

* IADL (Instrumental Activities of Daily Living): preparing meals, shopping, doing laundry, housekeeping, using the telephone, handling personal business, self-administering medications.

2. The ballooning costs of Medicaid for institutional long term care and the projected growth of the frail elderly population (those who are 85 and over) needing this care pushed policy makers to promote community-based and in-home care as a cost containment strategy.

3. The growing number of older adults and an increase in life expectancy focused research and political attention on the needs and preferences of older adults.

4. Services required by the growing number of older adults were inconsistently available, uncoordinated, often inaccessible, often unaffordable.

States have sponsored a variety of models of congregate housing/services programs, reflecting the growing acknowledgement that alternatives within a continuum of services, rather than several categorized care levels, are needed to appropriately meet the diverse needs of older adults. These models range from the minimum of assigning one case manager/broker to a "well elderly" senior housing project in order to facilitate residents' accessing available community services, to a housing facility specifically constructed for functionally impaired older adults to receive recreational, social, personal care, and nursing/medical services.

This report is an overview of the congregate housing/services industry in the United States, including several elements of the housing preferences of older adults, cost comparisons of institutional vs. housing/services environments, the advantages and disadvantages of combining housing and services, and a comparison of five states that have implemented one specific congregate housing/services model (Vermont, Maine, New Jersey, Maryland, and New York). The following were utilized to complete this report:

1. A review of the literature.

2. Discussions with officials of 18 state units on aging.

3. Site visits and discussions with the managers of a variety of private and public congregate housing/services programs and facilities.

The findings from several comprehensive studies were used as background information for this report:

1. An evaluation of the federal Department of Housing and Urban Development's Congregate Housing Services Program, by Sylvia Sherwood, et al, 1985.

2. A nationwide survey of public and private congregate programs by I. Malozemoff, J. Anderson and L. Rosenbaum for Urban Systems Research and Engineering, Inc., 1978. A stratified sample of 27 facilities representing three service levels, three rent levels, and four geographic regions of the United States was drawn from five major listings of housing for older adults.

3. A survey of residential care programs representational of the different types implemented in states east of the Mississippi River, by V. Mor, S. Sherwood, and C. Gutkin for the Hebrew Rehabilitation Center for the Aged, 1986. A combination of purposive and random sampling procedures were used to draw a sample of 230 state-supported residential programs in five eastern states.

Based upon this overview of the industry, several conclusions became apparent:

1. Per diem costs of care in a skilled nursing facility are substantially greater than per diem costs of care in a congregate housing/services facility. States justify the development of congregate programs on the basis of this per diem cost differential. On an individual case basis, net cost savings can be realized if a person who is inappropriately placed in a skilled nursing

facility is transferred from that facility to a congregate program, or if a person who is about to enter a nursing home is diverted to a congregate program.

2. The Diagnostic Related Groupings prospective reimbursement system for hospital acute care is resulting in longer and more intensive at-home recuperation periods requiring informal support beyond a level which families can reasonably manage. Also, in New York, the Resource Utilization Groupings reimbursement methodology for skilled nursing facilities provides a financial incentive for these facilities to accept the most ill patients (in order to achieve a higher reimbursement rate) in place of those requiring a lesser level of care who were previously preferred by nursing home operators. These two policy changes in public reimbursement systems have created a client shift in the continuum of services, leaving several categories of older adults with temporary impairment or low level chronic impairment with an insufficient supply of appropriate services.

3. Demographics indicate that the portion of the population aged 85+ termed the "frail elderly" will increase 40 per cent in the next 10 years and will require precisely that level of services provided by congregate housing/services programs. This increase in the frail elderly will coincide with a reduction in the younger age groups traditionally available to provide informal care for this group. It is estimated that up to three million elderly are currently funtionally eligible for congregate services.

4. The major differences between public and private congregate housing/services programs are the income level and functional impairment of the targeted populations and the range of services provided by operators. Private proprietary programs target private-pay clientele and typically provide congregate meals, housekeeping, 24-hour emergency response, and scheduled transportation. Private, non-profit programs target private-pay clients, but may partially subsidize a limited number of participants. Operators of these programs provide the same services as proprietary programs, but have begun modifying their services to include personal care and social services to accommodate the increasing frailty of their populations who are aging-in. Publicly supported programs target low income, frail clients. Personal care, social services, and, often, case management are an integral component of publicly supported programs, in addition to congregate meals, housekeeping, scheduled transportation, and 24-hour emergency response. Publicly supported programs are broadening their target groups to include higher income levels as a means of cross subsidization and in recognition of the service needs of all older adults.

5. Of the 18 states contacted for this report, five have implemented a program of subsidized services for a specified percentage of residents in existing senior housing projects. The major differences between these five congregate services programs are the reimbursement methodology and the program intent. Vermont, Maine, New Jersey, and Maryland tie their service subsidy funds to the program through a direct reimbursement to program operators from state general funds or specialized state funding streams, while New York ties service subsidy funds to the program participant via a state supplement to the resident's federal SSI payment. Vermont, Maine, New Jersey, and Maryland view their programs as a second line of defense; that is, as a mechanism for filling gaps and insufficiencies in the existing community service network, while New York views its program as a first line of defense; that is, as a separate program on the continuum-of-care, providing a coordinated total core set of services.

6. The advantages of congregate housing/services programs were found to be: the residential environment imitating life in the general community; the flexibility in meeting individualized needs; the promotion of aging-in- place and the reduction of relocation trauma; the increase in resident activity and morale; and the inherent financial incentive for operators

to provide minimum therapeutic intervention, which promotes residents' maintaining a sense of independence and decreases the potential for residents assuming a "patient mode." A potential disadvantage of congregate facilities that admit as residents only frail elderly who require a specified level of care is the creation of another segregated "institutionalized" living environment. Also, injecting a formal services program into a senior housing project for availability to only a limited number of participants often stigmatizes those participants as sick and generates fear among the remaining residents of turning their residential facility into a nursing home.

7. Evaluations of congregate housing/services programs by sponsors and independent researchers conclude that there is not one best concept model nor one best way to deliver the program's services.

8. Flexibility in service delivery to promote choice for participants is preferable. A formula for an "ideal" congregate housing/services program is difficult to achieve, and not necessarily desirable.

Sample Models of the Congregate Housing/Services Concept

- **Senior Resident Advisor Program** (operated by the New York City Public Housing Authority in 16 of its apartment buildings): A paraprofessional who lives in the building is available during the day to all residents of the building for counseling, information and referral, social activities, and brokering of community services. This person is also available 24 hours a day for emergency intervention.

- **Congregate Housing** (traditional model operated by private non-profit and proprietary sponsors throughout the country, for "well-elderly"): Apartments or cottages; residents pay a monthly fee which includes rent, utilities, 1 to 3 congregate meals, housekeeping/chore services, 24-hour emergency response, and essential transportation. Personal care services are individually contracted between residents and private vendors.

- **"Medical Model" Congregate Services Program** (private non-profit services programs operating throughout the country in "well-elderly" senior apartment buildings in which a significant number of residents have aged-in-place and are experiencing chronic impairments; usually operated in conjunction with the program sponsor's medical facility—nursing home or hospital): Residents pay a monthly fee which incudes the rent, utilities and traditional congregate facility services, but also includes operator-facilitated access to personal care services and facilitated access to the medical facility's staff and services.

- **Congregate Housing Facility** (often state-subsidized): Entry is limited to residents who are assessed as requiring congregate meals and supportive services. This program is similar to New York's Adult Homes except that each resident has his own private apartment, including a kitchen, and the facility does not always require licensure; abbreviated staff may remain on site during night hours.

- **Free Standing Shared-Living Residences, or Shared Apartments** (operating in many states): A small number (3-8) of unrelated individuals live together in a single family home or in an expanded apartment in a multi-unit apartment building and participate, as needed, in a program of supportive services which can include any of the following: congregate meals, housekeeping/chore service, social services, information and referral, transportation, personal care, case management, shopping aid, help with personal business matters and aid in managing self-medication. Operators and sponsors can be site-specific or can oversee several programs, sharing staff and equipment among programs in several locations.

- **Congregate Services Program** (state subsidized program of supportive services for a capped percentage of the residents in senior housing buildings): A specified number of an apartment building's residents receive any of a core set of services, including the traditional congregate services plus social services and personal care services. The program can be funded through a variety of means such as a state's general funds, a state's specialized funding stream such as lottery or casino revenues, a state's other in-home services program, a state's supplement to federal SSI grants. Program participants may be dispersed throughout the building or may be assigned to apartments on one designated floor or wing of the building.

Background

Persons aged 60 and over represent 16 per cent of the nation's population, and that figure is expected to grow to 26 per cent by 2025 (New York State Office For Aging, 1984). The fastest growing segment of this group is that portion typically referred to as the frail elderly, those who are 85 and over.

Medical advances and changes in life styles have resulted in a continuing increase in life expectancy. However, that period in the later years characterized by chronic impairment has also lengthened. The proportion of older adults who will require some measure of assistance in daily living, and the aggregate cost of this care, will increase dramatically.

During the 1970's and 1980's, in response to the impending growth in the number of frail elderly and the potential for great expenditure of public dollars, states implemented a variety of community-based service programs to replace costly institutional care for impaired older adults. This trend away from institutionalization is supported by gerontologists' findings that older persons negotiate the aging process more successfully if allowed to live as independently as possible, amid familiar surroundings, and with available choices in living environments.

Four situations came together to persuade states to develop community-based alternatives:

1. Specialized housing projects built in the 1960's and 1970's for low income, "well elderly" found that their resident populations did not turn over, but rather aged-in-place. Managers found it was difficult to force out an aged resident who needed only assistance in some daily activities in order to remain in an independent living environment.

2. The ballooning costs of Medicaid for long term care and the projected growth of the frail elderly population (85+) needing this care pushed policy makers to promote community-based and in-home care as a cost containment strategy.

3. The growing number of elderly and an increase in life expectancy focused research and political attention on the needs and preferences of older adults. Research showed that if their environment is a viable one, older persons prefer to age in place (Ward, 1985; Sherman, 1985; Lawton, 1978); and that involuntary relocation and over-intensive service intervention have detrimental physical and emotional effects on the elderly (Lieberman and Tobin, 1983).

4. Services required by the growing number of older adults are inconsistently available, uncoordinated, often inaccessible, often unaffordable.

One alternative community-based program developing across the country is termed the congregate housing/services concept — the integration of supportive services within a multi-unit residential housing facility. This concept advances the philosophy that housing is only one of a number of services required by older adults to maintain themselves as independently as possible in their later years, and that appropriate housing and necessary support services should be planned and delivered together when designing viable living environments for older persons. Traditionally, the support services included are congregate meals, housekeeping, linen service, scheduled transportation, 24-hour emergency response, and, in recent years, personal care (assistance with ADLs* and IADLs*). This provision of housing and

* ADL (Activities of Daily Living): bathing, toileting, grooming, dressing, transferring, mobility, eating.

* IADL (Instrumental Activities of Daily Living): preparing meals, shopping, doing laundry, housekeeping, using the telephone, handling personal business, self-administering medications.

services together provides a flexible, semi-independent residential environment for elderly persons to bridge the gap between the extremes of complete self-sufficiency and the custodial care of an institution.

In the United States, the congregate housing/services concept has its roots in the boarding house of earlier years where residents came together in a common dining room for the main meal of the day. They shared a common living room and often looked to each other and the boarding house owner for mutual assistance. However, the concept of sharing shelter, meals, and support is over 2,000 years old. What is new is governmental involvement over the past 20 years in promoting the development of the concept. Out of 18 states contacted for this report, 12 states defined their services-to-the-elderly programs as "congregate programs." Eight of these programs were initiated between 1976 and 1981. Through the Department of Housing and Urban Development, the federal government legislatively promoted the construction of congregate housing in 1970 and supplemented that effort with HUD's Congregate Housing Services Program in 1978 as a demonstration project (currently the program is operting in 62 sites in public housing and Section 202 facilities). Through a 1979 Memorandum of Understanding between the federal Administration on Aging and the federal Farmers Home Administration, a demonstration Congregate Housing program was implemented in ten sites across the country, with the Farmers Home Administration supporting construction loans and the Administration on Aging providing funds for supporting the services component. This program has not expanded significantly because supportive subsidies for the services component are no longer available.

While the fledgling publicly supported congregate housing/services endeavor is growing across the country, a well developed private congregate housing industry has developed and is expanding in response to a ready market for this housing alternative. Proprietary private congregate projects generally target higher income, well elderly who appreciate the safe environment and social opportunities and who often view the services as a convenience rather than a requirement. Traditionally, services in these facilities are congregate meals, housekeeping, scheduled transportation, and 24-hour emergency response. Residents have the option to contract privately for in-home health care when needed, but operators are adamant about residents leaving the project as soon as impairment compromises their independence.

Private, non-profit congregate projects target moderate income older adults, but many will subsidize a limited number of residents, using sponsor- or resident-endowed funds. Many non-profit congregate housing sponsors developed their services programs for frail residents in their "well-elderly senior housing" in response to the same aging-in phenomenon that is occurring in all senior housing across the country. A trend is seen among these sponsors to increase the number and intensity of available services to maintain their residents in independent living units and avoid relocation to institutions. These sponsors have added social services and a personal care component to their service package, and projects affiliated with hospitals and nursing homes make use of these institutions' professional staffs for congregate residents' medical and nursing needs.

Publicly sponsored programs target low income, frail elderly who are at risk of institutionalization. In addition to providing congregate meals, scheduled transportation, housekeeping, and 24-hour emergency response, social services, personal care, and, often, case management are an integral part of the service package.

Congregate housing/services programs state as their initial, formal intent, the provision of care up to but not including nursing beyond intermittant, short-term nursing care. This implies adherence to the traditional congregate housing philosophical intent to provide aid to persons who will remain independent if given some assistance with Activities of Daily Living, with those requiring a higher level of care moving from the congregate environment to an institutional level. In actuality, more and more residents are purchasing their own extensive in-home homemaking and nursing services, and many congregate facilities are treading a fine line between providing non-health and health-related services. It is not rare to find bed-fast individuals requiring 24-hour supervision and complete meal service.

The level of care required in congregate housing/services programs is gradually intensifying because of the increased longevity of residents, the public policy emphasis on delaying or avoiding institutionalization, the availability of in-home care providing service choices for individuals, and the cost of nursing home care inhibiting families from choosing nursing homes as a care alternative for their elderly family members.

Also, governmental policies and changes in health care reimbursement methodologies are resulting in an insufficient number of appropriate services for those who do not qualify for the intensive care of a skilled nursing facility, but who require more help than can be managed by families or the older persons themselves. For example, Florida consolidated its ICF/SNF rate into one reimbursement for SNF care and is finding that persons such as Alzheimer's and acting-out patients need more care than Florida's Adult Care Living Facilities can manage through their personal care level of services, but are too expensive to institutionalize at SNF rates. Florida is now considering a demonstration project of congregate homes for special groups which would be funded out of general funds because there is no medical reimbursement for these clients.

Two regulatory changes cause concern that the result will be the same in New York. The institution of the Resource Utilization Groupings method of nursing home reimbursement is motivating the operators of the restricted number of nursing homes to select only patients requiring very intensive levels of care in order to qualify for the highest reimbursement rates, leaving the previously preferred patients requiring less intensive care to choose other alternatives. Also, nationwide institution of the prospective payment system for hospital acute care (Diagnostic Related Groupings) has increased the at-home recuperation time of hospital patients, requiring a higher level of care than families and patients are prepared to handle.

Thus, greater life expectancy, lengthening periods of frailty, reluctance to relocate, in-home care alternatives, and policy/reimbursement changes are putting pressure on the congregate housing/services industry to serve a larger and increasingly impaired population.

Survey of States

- **State governments have instituted varying programmatic responses to service needs of older persons, and these responses directly reflect differing policy-level attitudes about the elderly.**
- **Congregate housing/services projects have developed in response to consumer need and have developed haphazardly across the United States in the absence of a macro-level elderly housing policy.**
- **Research/evaluations have shown there is not a generalizable "best way" to implement a congregate housing/services project. A major advantage of the concept is the variability inherent in designing viable models.**
- **State-supported congregate programs are funded through general funds, specialized funding streams such as casino revenues or state lotteries, SSI supplements, and additions to existing state-wide social services program funding streams.**
- **Vermont, Maine, Maryland, and New Jersey offer congregate services programs similar to New York's Enriched Housing Program. New York's program differs in reimbursement methodology and in program intent from the programs of the other four states.**

The development of community-based services, including congregate housing/services programs, has not progressed in a consistent manner across the country. State governments have instituted varying programmatic responses to the service needs of older persons, and these responses reflect differing policy-level attitudes about the elderly:

Some states have only a few elderly, have not felt the political pressure to respond to that constituency, and have little or no elderly housing/services programs.

Some state policy makers address the issue of age segregation. For example, Wisconsin does not wish to separate (ghettoize) its older adults from the rest of the community and wishes to discourage the growth of large care facilities which connote institutional living. Wisconsin has initiated a $16M Community Options Program for all ages of medicaid-eligible persons who are at risk of institutional placement, and provides whatever services are needed to keep these persons in their own homes or in facilities housing one to nine persons. On the other hand, Connecticut's congregate housing program segregates frail elderly through the construction or rehabilitation of facilities specifically designed as congregate facilities for residents whose functional level requires assistance.

Other states are attempting to increase service options to all older adults rather than focusing on a particular sub-category such as "frail" or "low-income." Maryland is an example. In an attempt to make the existing large private pay congregate housing industry available to low/moderate income elderly, the state of Maryland has instituted a capped subsidy to augment a sliding scale to provide shelter and services in family homes certified to care for 4 - 15 persons. Maryland also has a congregate services program in existing subsidized senior housing; and, in response to requests from the managers of unsubsidized senior housing developments, the Maryland Office On Aging will provide technical assistance and certification to implement their services program on a private pay basis for those older adults who do not qualify for subsidies but who cannot afford Life Care Communities.

Ohio uses its monies to promote the development of congregate housing/services projects for well elderly with an incentive grant for construction. The Department of

Aging controls rents, but does not subsidize services. Ohio also has an Adult Home program for those who need the personal care level of services.

The state of Massachusetts provides for congregate shelter and services through shared apartments and family homes, but all congregate housing residents receive any needed services through the state-wide $109M home care program serving 46,750 clients in the general community. Massachusetts plans to change its income guidelines to allow higher income older adults to participate in the congregate shelter/services program.

Most states offering a program they define as congregate housing have a number of additional programs in place to offer alternatives to older adults who are less than self-sufficient. One example is Pennsylvania which has Personal Care Boarding Homes, a Shared Housing Program, a Domiciliary Care Program, Department of Housing and Urban Development congregate services projects, an in-home service management system, as well as an extensive state-regulated Continuing Care Retirement Community industry.

In addition to government-sponsored congregate housing/services projects, all states have seen the development of a diverse private congregate housing industry, with rate structures and services reflecting the targeted income group. Sponsorship varies widely, including non-profit organizations, individuals, religious groups, hospitals, nursing homes, public housing authorities, area agencies on aging, proprietary developers, corporations, and health care chains.

Definition of Congregate Housing

Theoretically, any shared living arrangement among a group of unrelated persons of any age operating as an economic unit is a congregate housing arrangement. Currently, however, the term "congregate housing" is used by public policy makers to specify a housing environment for older adults (aged 60+) which integrates private apartment living with supportive services. The lowest common denominator shared by housing projects designated as congregate facilities is a private living unit together with the availability of a congregate meal program operating in a central dining room (Urban Systems, 1976).

A major advantage of the congregate housing/services concept is the variability inherent in designing models of the concept. While this allows for flexibly addressing needs and preferences of targeted resident populations, it makes definition and description of the concept difficult and cost comparisons between states and programs inconclusive. Several examples will illustrate this difficulty in specificity and comparability:

1. Sherwood, et al, (1986) surveyed 118 congregate programs nationwide that were identified by 21 different names, included different population profiles, and encompassed a range of services.

2. Congregate housing is defined in the 1970 United States Housing Act as "low rent housing in which some or all of the dwelling units do not have kitchen facilities, and connected with which there is a central dining facility to provide . . . meals for elderly families under terms and conditions to permit a self supporting operation."

3. Powell Lawton (1976) states that the term congregate housing has no satisfactorily accurate definition. For his study of the impact of congregate and traditional housing on elderly tenants, he defines congregate as housing that offers a minimum service package that includes some on-site meals served in a common dining room, plus one or more of such services as on-site medical/nursing service, personal care, or housekeeping.

4. The state of Connecticut defines congregate housing as "a form of residential environment, consisting of independent living assisted by congregate meals, housekeeping and personal service for persons 62 or older, who have temporary or periodic difficulties with one or more essential activities of daily living, such as feeding, bathing, grooming, dressing, or transferring" (Congregate Housing Study Committee, 1985).

5. The state of Vermont defines congregate housing as a combination of shelter, nutrition, housekeeping, and personal and social services provided in part through government assistance to elderly residents in a facility containing independent apartments and a common dining room (Guidelines, 1977).

6. For the state of Massachusetts, a congregate house can have as few as four residents or more than 50; the setting can be one large, shared apartment or a shared one-family home, or small apartments in a larger conventional building. "Living in a congregate house means coping with a set of unique issues and problems on a daily basis. These include residents' psychological expectations, their diverse support networks, sharing, incapacity, and leaving. Residents in congregate housing must be seen in terms of their physical shelter needs, service requirements, and social abilities, and all of these as they change over time" (Massachusetts Department of Elder Affairs, 1984).

7. According to Mor, *et al.* (1986), the Federal Register classifies any home which routinely provides more than room and board to the public as a residential care home (alternately known as domiciliary care, *congregate care*, or adult foster care). Palmer estimated that there were 600,000 residents in residential care facilities in 1983 across the United States (Mor, 1986), with the types of homes and their names differing from state to state and within states as a function of the type of population served. Mor estimated that elderly residents constitute between 40 and 60 per cent of these residential care facilities.

Mor, Sherwood and Gutkin's (1986) nationwide survey of residential care programs used the definition "a set of living arrangements operated by someone unrelated to the residents, which provide room, board, and personal care or supervision. . ." However, the residential care homes identified by Mor, while "also known as congregate care," are generally state-licensed and regulated Residential Care Facilities (alternately known as adult homes and assisted living facilities). These facilities should be differentiated from what is generally considered to be congregate housing or what is meant by the congregate housing/services concept in this report. The two can be confused because the range of services provided and the characteristics of the resident populations in both are often the same. However, state regulated and licensed Residential Care Facilities are constructed specifically to house individuals assessed as requiring services prior to admittance to the facility. RCFs predominately provide private bedrooms rather than private, complete apartments for residents. They mandate the provision of three congregate meals per day, provide a routine core set of services to all residents, and are more "institutionally" defined in terms of beds rather than in terms of independent living units.

Residential Care Facilities can be viewed as a level of care rather than as a housing option. In contrast, facilities which fall within the congregate housing/services concept developed from a social model perspective. They provide the same range of services as RCFs, but these services are elective and made available as an in-home services program to residents in their private apartments. They do not require licensure or state regulation; and while many facilitate the provision of personal care services, these services are contracted individually by the resident and a private home health agency.

Definitional lines begin to blur when states institute subsidized congregate housing/services programs in senior housing buildings and require regulation and monitoring by a designated state agency. An example is New York State's Enriched Housing Program which is a state-supported services program (including a congregate meal, social services, and program-sponsored personal care) for a capped number of residents in well-elderly senior housing buildings. While program participants are dispersed throughout the building, reside in their own private apartments, and utilize only those services they are assessed as needing, all participants are charged a standard fee for a set package of services, the program is certified and licensed as a New York State Adult Residential Care Facility, and the monitoring agency (New York State Department of Social Services) does not consider the program a congregate housing/services program. In contrast, Maine, Vermont, Maryland, and New Jersey have state-supported programs similar to New York's Enriched Housing Program and do define theirs as congregate programs.

8. As the frail elderly population has grown in number, health care industry developers (nursing homes, hospitals, health maintenance organizations) have begun focusing on this population as an avenue for diversification. These developers draw a definitional distinction between "congregate housing" and "assisted living," with congregate housing being defined as "one step up from independent living" and assisted living defined as "one step down from a skilled nursing facility." The implication is that assisted living requires the provision of a higher level of services than does congregate housing. However, residents of existing congregate facilities around the country often require the same intensity of service care as those targeted for assisted living facilities. The actual difference between the two options appears to be the same as between congregate housing/services projects and residential care facilities. Very often, personal care services are provided by an assisted living sponsor as part of the monthly fee, making these facilities subject to the same licensure as residential care facilities.

9. As the concept of integrating housing and services has grown in acceptance, modified versions continue to be created. For example, a Continuing Care Retirement Community is a specialized housing and supportive services environment with a medical component (skilled nursing facility). It is a congregate campus community accessible to higher income elderly which incorporates contractual lifetime tenancy and care. A Brandeis University/Philadelphia Friends Services for the Aging joint project will develop a non-campus CCRC model for moderate/lower income older adults who will continue to remain in their own homes in the general community, but a finite group will share medical and social services. A Senior Resident Advisor Program in New York City's Public Housing Authority senior housing projects does not include congregate meals but does provide on-site staff to provide counseling, coordination/brokering of community services, and 24-hour crisis intervention for residents. In Pennsylvania, Lehigh County is involved in assisting the development of congregate housing under a "cooperative" arrangement, with residents buying "shares" in the housing component and services provided by several religious-affiliated sponsors working together as a non-profit umbrella coordinating organization.

Across the country, congregate housing/services programs have developed in response to consumer demand and have developed haphazardly in the absence of a macro-level elderly housing policy. Program sponsors and operators have had no prototype to copy, but have created their own models to address the particular needs of their specific populations. Thus, the congregate housing/services concept has many faces. However, the basic programmatic parameters and the fundamental intent are always the same: (1) it is the integration of a private living environment and elective supportive services; (2) it is intended to enhance and maintain private, independent living and delay or avoid institutionalization.

States, through research, pilot projects, and permanent programming, have not determined a generalizable "best way" to deliver the programs; thus, no state has instituted a formulated model throughout its state. The same services are delivered in a myriad of ways and at variations in cost dependent upon such variables as:

- Whether a service is locally available through another funding stream.
- Whether a service can be contracted through a nearby provider, or must be provided by site staff (urban vs. rural/suburban issue).
- The extent of community involvement in the program (volunteer staff, paraprofessionals, local monetary and in-kind contributions).
- A resident population's functional profile (paraprofessional vs. professional staff).
- The number of a program's participants (circuit rider coordinator, shared staff, part-time/full-time staff).
- The political environment in each locale, dictating which organizations serve which populations.
- The extent of cooperation among local agencies to pool resources (for example, transportation).
- Whether the locale is services rich or poor (competitive prices and quality of services available; unique local services; contracted vs. onsite staff).

Comparison of State-Sponsored Programs in New York, Vermont, Maine, New Jersey, Maryland

This "Review of Congregate Housing in the United States" is meant primarily as an educational tool for program and policy analysts in New York for use in shaping the future development of the congregate housing/services concept in New York. Thus, this section of the report will compare New York's current state-sponsored congregate housing/services program with the state-sponsored programs of four states, of the 18 surveyed, whose programs are structurally similar to New York's.

States set congregate housing/services subsidy eligibility requirements based on income and functional level. One of the easiest ways to target a state's low-income, frail population is to focus the congregate housing/services program on frail elderly in independent senior housing projects. A number of states have done this, including Vermont, Maine, New Jersey, Maryland, and New York.

All five of these states dictate that program participants require help because of ADL impairment, but not need continuous nursing.

All five offer the same core group of services: varying numbers of congregate meals, housekeeping, homemaking/chore, scheduled transportation, 24-hour emergency response, social services, personal care, and brokering for needed services not directly provided by program staff.

Four of the programs are administered by the states' Offices on Aging; New York's program is called Enriched Housing and is administered by the State Department of Social Services.

The aggregate amount of money each of the five states spends varies, as does the average monthly state subsidy per person for the program:

State	Annual State Expend.	Total No. Partic.	Avg. Mon. Subsidy Per Person	Source of Funds
Vermont	$47,000 ($106,800 appropri.)	89	$ 44 ($100 Cap)	Gen. Funds
Maine	$300,000	169	150 ($150 Cap)	Gen. Funds
New Jersey	$800,000	590	113 (No Cap)	Casino Rev.
Maryland	1.1M	902	100 ($100 Cap)	Gen. Funds
New York	1.2M	382	250 ($365/395 Cap)	SSI II

There is wide variance in the five states' average subsidy per person per month. A critical factor which explains the variance between New York's and the other four states' average service subsidy is each program's designated purpose within the existing services network. Vermont, Maine, New Jersey, and Maryland mandate that existing federal, state, and local programs and funding streams be used first, with the congregate services program used to supplement insufficient services or gaps in services. Therefore, Medicaid, Titles III-B and C of the Older Americans Act, local transportation entitlement programs, Title XX of the Social Security Act, food stamps, USDA surplus food and other welfare programs, etc., are utilized before congregate program funds.

The reverse is true in New York, with the congregate services program (Enriched Housing) being the first line of defense for program participants before other funding streams are utilized. For example, in New York the Enriched Housing Program is mandated to provide one congregate meal per day utilizing program staff and funds even if other congregate meal programs are easily accessible. If an Enriched Housing resident is assessed as needing one congregate meal per day and she participates in an Older Americans Act Title III-C congregate meal site program, that III-C meal will be considered the resident's second congregate meal of the day and she must still participate in the Enriched Housing Program's congregate meal. The III-C meal funded with federal dollars is not used in place of the Enriched Housing Program's meal. Also, an Enriched Housing participant's first six hours of weekly homemaker/personal care services must be provided via the Enriched Housing Program's staff and funds. Homemaker/personal care needs which go beyond the initial six hours can then be met with other funding sources such as Medicaid.

The intent in New York reflects a desire to provide a total, coordinated, cohesive program as a means of addressing fragmentation, inaccessibility, and inconsistency in the community service system. Each discrete building's Enriched Housing program of services is developed for and delivered to only the residents of that housing facility. The intent in the other four states is to use the program to provide a formal mechanism for locating and filling gaps and insufficiencies in the existing community service system. Access to services which are available to the wider community is facilitated and coordinated for delivery to congregate program participants by the congregate program's coordinator.

Other elements contribute to the five states' average subsidy variance:

1. Program mandates: Vermont's program ($44 average subsidy) does not *mandate* the provision of congregate meals, and any weekday congregate meals required by participants are provided through the Older Americans Act Title III-C program. Thus, the $44 figure does not include meal service. Maryland (average: $100) mandates three congregate meals a day and utilizes III-C to the extent possible. New York (average: $250) mandates one congregate meal a day to be provided with Enriched Housing Program funds.

2. Participants' contribution to program costs: Although all five programs target low income elderly, no state dictates a ratio of private pay to subsidized participants. All five states allow private pay eligibility for participants above designated income limits, and all utilize a sliding scale formula to determine participants' contributions. The aggregate average income of a program's subsidized participants will affect the average subsidy per program participant. For example, only 22 per cent of Maryland's ($100) participants are SSI eligible, whereas 75 per cent of New York's ($250) are SSI eligible. However, it should be noted, in comparing New York's Enriched Housing Program's average services costs per month to other states' average congregate services costs, that the average cost to New York for this specific program is not $250 but is, in reality, $178. The program's subsidies are funded out of the state's Supplemental Security Income Program at the "Congregate Living Level II" for Adult Residential Care Facilities. If an Enriched Housing participant drops out of the Enriched Housing Program, he would no longer be eligible for the Level II (Congregate Living) subsidy, but would continue to be eligible for the state SSI subsidy at Level I ($71.91), the state's "Individual Living Alone" grant ($250 - $71.91 = $178.09).

3. Cost-sharing formula: New Jersey ($113) has the median average monthly subsidy. New Jersey determines its subsidy by a formula which involves a percentage of the service plan cost for each individual relative to his discretionary income together with the cost for each service in that individual's project area. Subsidies are limited to those whose *discretionary* income is less than 126 per cent of the OMB poverty level, and every participant must pay at least five per cent of his service costs. Average monthly participant contribution is $76. Maine ($150) does not have a uniform statewide methodology for determining participant contribution, but each program

operator has discretion to develop his own cost- sharing formula. Vermont's ($44) method of computing participant contribution is uniform statewide, and subsidies are limited to those whose incomes are below 80 per cent of the median income in their counties.

Maryland ($100) specifies no income eligibility criteria, but the program is located in publicly assisted housing. Participant cost-sharing is determined as a portion of gross income minus 10 per cent, personal allowance, rent, food and medical expenses. However, Maryland's tenant selection process for any one project factors in applicants' income ranges, age ranges, and functional levels to arrive at a case mix such that the average state subsidy of $100 per person is not exceeded at any one project. New York's subsidy ($250 average) is available to participants who are SSI eligible. New York has developed a legislatively set "standard of monthly need" which includes room, board, and supportive services. In 1987, this "need" cost figure was $705/735 (upstate/downstate). A participant eligible for the program's subsidy qualified for the state's SSI Congregate Living Level II supplemental funds in an amount which, when added to his own countable income and his federal SSI grant ($340), equaled $705/735.

4. Program components eligible for reimbursement with state funds: Maine ($150) will reimburse for a portion of administrative, housing director, and transportation expenses; a part-time care manager (AAA staff); on-site food service staff and food supplies if III-C cannot be accessed; home health agency sub-contracts or, if too expensive, homemaker staff costs. Maryland ($100) will reimburse for food service costs if III- C cannot be accessed, a program coordinator, direct homemaker staff or home health agency sub-contract, counseling, some transportation.

New Jersey ($113) will reimburse for a coordinator, home health agency sub-contract or part time homemaker aides, food service costs if III-C cannot be accessed, transportation for food service, other costs related to food. Vermont ($44) pays for a part-time coordinator, weekend meals and special diet meals, home health agency sub-contract or part time homemaker aides, some transportation, a portion of the AAA director and bookkeeper, and lifeline. New York ($250) pays for food service staff and supplies, home health agency sub-contract or part-time homemaker aides, scheduled transportation, program coordinator.

5. In addition to services listed as core program components, operators in the five states provide discrete ancillary, non-medical services assessed as required by a participant to have his needs met in order to maintain independence. These are normally reported in the budget under "other," and can vary widely from project to project. Projects' use of volunteers also varies, and these in-kind costs are not included in determining average program costs. None of the five states' program subsidies includes costs of shelter, and only New York provides a one-time separate start-up grant for program planning and development.

6. A possible reason why Maine subsidizes at a 50 per cent higher figure than Maryland and Vermont may be the differences in these programs' initiation dates. States will attempt to arrive at a subsidy figure through a state-wide survey of service-unit costs or through the results of a demonstration project. Both Maryland's ($100) and Vermont's ($100) programs were begun in the late 1970's whereas Maine's ($150) started in 1984 when labor, food, and other costs were higher. Maryland's new (1986) family home congregate services program will be subsidized at $200 per person per month based on a very recent survey of costs across the state. In New York, subsidy amounts are legislatively set and revised in response to a periodic determination of "a standard of monthly need" dependent upon the type of living

arrangement (living alone, with others, with a family, in a residential care facility, in a school for mentally retarded) and the geographic area in which the eligible individual resides (upstate/downstate).

New Jersey has no subsidy cap, but wants to change its method of subsidy determination, to reduce complexity and paperwork. A possibility considered is for the Division on Aging to determine a state-wide or a regional cost per unit for each service in the program and a standard salary for the position of coordinator. An individual project would submit a projected budget for the number of residents and the number of service units needed for those residents. The state would then pay a certain percentage (for example, 75%) of the cost of the coordinator and the services based on the state or regionally determined per unit cost. The operator would be responsible for the other 25 per cent through private contributions or other funding.

In four of the five states (Vermont, Maine, New Jersey, and Maryland), each project submits an annual projected budget to the state and is reimbursed quarterly during the year. In these states, subsidy monies flow from the state directly to the sponsor or operator in direct response to the projected program budget which is based on each individual's service needs, other funding sources, and the project's unique configuration of services, delivery methods, and staff make-up. In New York, a program participant will receive one monthly check from the federal government which includes both his computed state and federal SSI grants; and he must turn this payment (plus any assessed participant contribution) over to the project operator, less a very modest personal allowance. In contrast to the other four states' programs, each participant is not charged according to his service plan, but is assesed an identical amount ($705/735) to cover services/rent/board regardless of his service utilization rate and regardless of each project's services/staff/delivery configuration.

STATE	VERMONT	MAINE	NEW JERSEY	MARYLAND	NEW YORK
YEAR BEGAN	1979	1984	1981	1976	1979
DESCRIPTION	Prog. avail. to up to 33% of resid. pop. of pub. sen. housing facilities.	Prog. avail. to up to 20-30% of resid. pop. of sen. hous. facs.	Prog. avail. to up to 25% of resid. pop. of pub. sen. hous. facs.	Prog. avail. to up to 10-25% of resid. pop. of pub. sen. hous. facs.	Prog. avail. to up to 25% of resid. pop. of pub. sen. hous. facs.
OVERSIGHT	Aging Dept.	Aging Dept.	Aging Dept.	Aging Dept.	Social Services Dept.
LICENSE	Demonstration project through AAAs.	Aging Dept.	Not Required	Certified by Aging Dept.	Social Services Dept.
SPONSORS	Private proprietary/non-profit; housing authorities; joint public/private; AAAs.	Joint sponsorship by AAA and local housing developers.	Senior housing non-profits; limited dividend partnership.	Housing authorities; non-profit organizations.	Private/public non-profits; housing authorities.
SOURCE OF SUBSIDITY FUNDS	General funds supplement Title III community grants	General funds	State casino revenues.	General funds.	State SSI Supplement.
MONEY FLOW	AAA contracts w/ sponsor or service provider; AAA submits annual projected budget to Aging; Quarterly advance of funds to AAA.	Project submits annual projected budget; quarterly advances from Aging to operator or through AAA	Formula: varying % of program cost subsidized relative to discretionary income of resid; projected budget sent to Aging; funds paid to operator.	Sponsor submits annual projected budget to Aging; monies sent to sponsor through AAA.	Fed & State SSI funds sent to resid; all pay operator same amount for services & rent.
STATE'S ANNUAL COST	$106,800, cap $100 per person/mo.	$294,000; cap $150 per person/mo.	$800,000 No cap	$1.1M; cap $100 per person/mo.	$1.2M; cap: $365/395 per person per month
CLIENT ELIGIBILITY	62+, frail, but no medical supervision; income: 80% of county median income; private pay w/no subsidy.	60+, below ICF/SNF el.; No fin. el. criteria	Elderly w/ADL impairments; self-ambulatory; financial el.: discretionary income less than 126% of OMB poverty level.	62+ w/ADL impairment. No financial el.; all in subsidized housing.	65+ w/ADL impairment; 18+ disabled; no continuous nursing; SSI eligible.
# FACILITIES	17 (5 AAA regions)	16	30 (23 operators)	27	51 (25 operators)
# RESIDENTS	89 slots	169	Avg: 590/month	902	382 (600 slots)
STATE'S MONTHLY PROG. COST	$44 per person	$150 per person	$113 per person	$100 per person	$250 per person (est.)
COST SHARING	Sliding scale	Sliding scale	Sliding scale	Sliding scale	Sliding scale
SERVICES	Standard*	Standard*	Standard*	Standard*	Standard*
SER. DELIVERY	Own Staff; contracted	Own staff; contracted	Own staff; contracted	Own staff; contracted	Own staff; contracted
SER. PURCHASED BY RESIDS.	As needed; subsidy paid to operator.	As needed; subsidy paid to operator.	As needed; subsidy paid to operator.	As needed; subsidy paid to operator.	Package; subsidy paid to residents.
STAFF	AAA staff; circuit rider.	Care manager (employee of AAA) part-time staff; vols.	Prog. Coordinator; as needed staff & vols.	Site Coordinator; meal staff varies.	Coordinator; per care; housekeepers; food service staff
# MEALS MANDATED	None	1	1	3	1
MEAL DEL. METHOD	Weekdays Title III-C; weekends: staff; contracted	Title III-C; own staff; contracted.	Title III-C; own staff; contracted	Title III-C; own staff; restaurant; contracted.	Own staff.
RESID. PRIVATE KITCHEN	Y	Yes	Yes	Yes	Yes
COMMENT		Will review if $150 per person/mo. is a realistic figure.	Want $1.2M to expand program next year. Trying to change pay procedure to reduce complexity.	10-year eval. due in 1987. Aging Office now giving TA & certification to priv. developers for priv. pay, moderate income elderly.	Program regulations are currently being re-evaluated. Consideration is being given to extending services to non-program residents.

*Standard Service Package: Congregate Meal, Housekeeping, Personal Care, Transportation, Laundry, Social Services

Are Congregate Housing/Services Programs Cost-Effective Relative to Institutional Care and In-Home Care?

- **Comparatively, congregate housing/services per diem costs are substantially less than nursing home per diem costs.**
- **Congregate programs result in *per person* savings in instances where nursing home patients are transferred to a congregate housing/services program or an individual about to enter a nursing home is diverted, instead, to a congregate program.**
- ***Aggregate* costs of a congregate housing/services program are greater than net savings from the relatively few averted or transferred nursing home placements.**
- **Most cost comparisons of congregate housing/services programs with other in-home service programs have been unreliably measured and are, therefore, inconclusive.**
- **The argument for community-based and congregate services should not be to avert institutionalization, but to enhance the quality of life for a substantial segment of the older population, to serve as a preventive measure for the mental depression common among older elderly, to augment communities' informal support systems, and to mediate the increasing pressures on housing managers.**

The issue of cost effectiveness, as it relates to congregate housing, is extremely complex. There is lack of agreement among researchers on a methodology for calculating the cost of congregage housing, and a rigorous framework for analyzing the issue has yet to be developed. Thus, the research produces inconsistent results, and findings are inconclusive. Some researchers view congregate housing as a more appropriate alternative to nursing home care while others view this option as an alternative to the traditional method of providing home care.

There is widespread reporting that providing shelter and services via congregate housing/services is less expensive than providing shelter and services in an institutional setting (skilled nursing facility, health related facility), and states that have instituted a congregate services program couch their justification in terms such as "delaying or avoiding institutionalization in order to provide a more appropriate environment for the elderly and to contain the high costs of institutional care."

Cost comparisons are often stated. For example, Connecticut's congregate program average monthly cost per person is $645 compared to $1,178 which is that state's portion of average monthly medicaid reimbursement per nursing home patient. New York's average monthly subsidy cost per person in the state's Enriched Housing Program is $250 (funded from general funds through the state's SSI Program) vs. $1,042, which is the State's average portion of medicaid reimbursement per nursing home patient. Massachusetts compared the cost of maintaining 114 congregate housing residents with the cost of nursing home care. Twenty one of the 114 had previously lived in nursing homes. The average cost of Level III nursing home care (comparable to congregate-profile service care) for the 21 residents was $1,116 per month and covered nursing, room and board, laundry, recreation, aide services, orderlies, dietary, and administrative staff. Average cost of congregate care for these 21 residents was $880.48 per month and included shelter costs (development and debt service), board, health and social services, management services, homemaker, personal care, chore, counseling, transportation, and day care.

A 1981 study by the Massachusetts Department of Public Welfare, comparing Level III nursing home care with a HUD Congregate Housing and Services project and a small private congregate project concluded that the annual cost of institutional care in an Intermediate Care Level III Facility would be $9,842, which is $2,400 to $3,500 more per year than the cost of maintaining an individual in either of the two congregate facilities.

Nenno, Nachison and Anderson (1985) cite an analysis in Illinois which found that a full congregate housing/services program could be provided for $10 to $14 a day per person compared with government covered skilled nursing care at $27 a day. Heumann, *et al* (1985) compared costs of seven congregate facilities with the costs of comparable-profile residents of six nursing homes in Illinois and found the average monthly cost per congregate resident to be $623 and the average monthly cost of comparable nursing home residents to be $702.

Thus, some of those residents currently inappropriately placed in nursing homes; that is, requiring a less intensive level of care than is provided in a nursing home could be currently more appropriately cared for in a congregate setting (non-institutional, non-medical, minimum intervention environment) and at a significantly lower cost, supporting the argument for transferring functionally eligible elderly from institutional care into residential congregate programs.

There is conflicting opinion (and no clear data on a national basis) about the proportion of nursing home patients who are "inappropriately placed." Davis and Gibbin (1971) estimate the proportion at 10 per cent. Nancy Anderson (1975), using six measures of competence, found 18 per cent inappropriately in nursing homes, but concludes that only nine per cent could be cost effectively cared for in alternative programs. In 1983, the Minnesota Department of Welfare estimated the figure at 40 per cent (Nachison, 1985), as does Elaine Anderson (1985). A United States Government Accounting Office study concluded that 11 per cent of elderly in institutions could utilize congregate housing (Mass. Final Report, 1984).

Sixteen per cent of the residents in Massachusetts' state funded congregate projects came from nursing homes; 11 per cent of HUD's congregate residents filling turnover slots came from nursing homes; and between 5 and 10 per cent of New York's Enriched Housing Program came out of institutions. This is not the same as saying that 16, 11, or 10 per cent of nursing home patients moved to congregate projects.

The conflicting estimates of inappropriate placements may soon be academic because the Resource Utilization Groupings (RUGs) reimbursement methodology instituted in New York in January, 1986, has increased incentives to nursing homes to reverse their previous admission policies to prefer the heavy-care category patient over the light-care patient in order to achieve higher reimbursement rates. For the period from the institution of RUGs through the summer of 1987, the number of Medicaid patients in New York's nursing homes in the heaviest care category has tripled and the number in the lightest care category has fallen by 24 per cent (Wolff, 1987).

It is easy to mistakenly extrapolate nursing home vs. congregate costs to assume large aggregate service cost savings based on the number of residents in a congregate program. For example, according to Nenno, Nachison, and Anderson (1985), nursing home costs to the federal government averaged $14,510 per person per year while total congregate cost to the federal government averaged $4,589 per person per year. "Thus, the cost of congregate services was only 32 per cent of institutional care." "For each dollar spent on CHS Program services per participant annually, three dollars can be saved" (Anderson, 1985). The implications of this comparison can be misleading if it is inferred that the government is saving money on all congregate clients. A per person net savings occurs only for those persons in a nursing home or about to enter a nursing home who are placed, instead, in a congregate program.

After evaluating HUD's Congregate Housing and Services program, the conclusion of Sherwood, et al, (1986) was that the most critical variable in making an impact on costs is identifying *when* people are about to make a housing change. Congregate, as compared with institutional care, is only cost effective when you take as residents people who are currently in institutions and who can be relocated to congregate or those in the community who are about to actually move into an institution (Sherwood, *et al.* 1986) (not necessarily those who are merely deemed eligible for institutionalization). Only 20 per cent of those eligible for nursing home care actually enter nursing homes (Sherwood, 1987).

In the HUD Congregate Housing Services Program, an average of three people per CHS Program site were transfers from institutions (Anderson, 1985). This totaled 189 out of 2,200 total program participants, and cost savings can be assumed for these 189 persons. However, three fourths of the CHS program's residents were assessed as "not likely to be institutionalized" prior to program implementation (Sherwood, 1985). Without a congregate program available, these persons would most likely have found alternative community-based or family care. Thus, availability of a congregate program for these persons is not saving the additional cost of institutional care.

The 32 per cent figure stated above is significant only if one can truthfully say that, without the congregate program, clients now receiving the congregate housing/services program would have actually been inappropriately placed in nursing homes and that those congregate clients who subsequently became nursing home eligible would have actually entered nursing homes instead of dying at home, going to live with family, or employing in-home help.

A study by Morris, *et al.* (in press) supports the view that the purpose of housing/services programs is not primarily to reduce institutionalization. The authors compared four housing/services options (case-managed home care, congregate/housing/services, age-segregated senior housing with no case managed home care, and age-segregated senior housing with case managed home care) with a control group of seniors living in private homes/apartments with no case management services, utilizing four institutional-risk categories (Very Low, Low, Some, High) to compare days of institutional placement. Analysis found a positive role in providing case management services in congregate and elderly housing settings for those clients in the High risk category. However, case management made no difference in long term facility placement rates or days spent in long term care facilities for those in the Some, Low, and Very Low categories.

A longitudinal benefit/cost analysis (using a control group) of the Highland Heights *medically oriented* congregate program was done over a three year period by Sylvia Sherwood (1981) comparing institutional vs. congregate costs. This program did reduce institutional days. Sherwood defined benefit as societal costs (cost of days in long term and acute institutions) that would have been incurred, but were averted, as a result of the Highland Heights intervention. Translating all dollar amounts into 1977 dollars, Sherwood found that for the 214 resident sample (compared with 214 controls who were matched individuals from the pool of applicants to Highland Heights) the benefit/cost ratio for the three years were 2.83, 2.15, and .62. That is, while the total costs (housing and services) of maintaining persons in the congregate program was greater each year than the costs of housing and services incurred by the controls in the community, the amount of money saved because of the reduced number of institutional days of the congregate residents (benefits) resulted in a *net* dollar *benefit* of $339,712 the first year, $141,682 the second year, and a *net loss* the third year of $25,971.

Cumulatively, for the three year period, the savings were $445,423 and the *cumulative* benefit/cost ratio was 2.21. These analysis figures apply to following the same initial group of 214 persons over the three year period. If the analysis was done with a constant pool of residents (movers and deaths replaced with new, less impaired occupants), the benefit/cost ratio for the three years was 2.83, 2.29, 1.43, with a 2.29 cumulative benefit/cost ratio over the three years. Thus, in the case of both a finite sample and a constant sample, the benefit in the third year drops dramatically even though the cumulative benefit is still significant. A critical study would be one which determines the number of years before the *cumulative* benefit/cost ratio becomes negative.

Critical in the cost comparison between institutional care and congregate programs is the fact that congregate housing/services programs do not target only inappropriately placed nursing home patients or those about to enter a nursing home. Congregate program subsidies support congregate participants who are non-nursing-home-eligible. Thus, while congregate care is comparatively cost effective relative to nursing home care costs, the argument for the expansion of these programs cannot be made on the basis of absolute savings. The net amount saved for the smaller number of nursing home aversions and relocations is more than offset by the aggregate costs of providing the congregate program for the total number of program participants.

In addition, the agency that pays for the congregate housing/services program is not necessarily the one that accrues any potential comparative savings. Depending upon program participants' income levels, states may pay aggregately more of the lesser congregate costs, which are non-medical and thus not covered by Medicaid except with special waivers. States' revenues normally subsidize state-sponsored congregate housing/services programs while the federal government contributes to the more costly nursing home costs at a 50/50 split. In transferring residents from nursing homes to congregate, there may be a significant shift in cost coverage from federal to state programs. Several examples: In Massachusetts (Mass. Final Report, 1984), for 20 cases of transfer, federal payments were 31.5 per cent of patient costs when the 20 were nursing home residents, but were 8.5 per cent of patient costs when the 20 were in congregate. The state's portion of costs went from 31.4 per cent when the 20 were institutionalized to 77 per cent when they were placed in congregate. Residents' contributions to costs included SSI, social security, and pensions, and are, therefore, primarily income from federal programs. If residents' contributions are added to federal program payments, the federal/resident portion is 68.5 per cent while in institutions and 22 per cent while in congregate.

Mass. 20 cases	**Fed.**	**Resid.**	**Fed./ Resid.**	**State**
Instit. Care Paid:	31.5%	37%	68.5%	31.4%
Congre. Care Paid:	8.5%	13.4%	22%	77%

In Illinois, the "sheltered care" (lowest of three levels of institutional nursing care, characteristic of those residents most easily transferred to congregate housing/services programs) reimbursement rate is kept low and new sheltered care beds are slow to be approved because sheltered care is entirely reimbursed through state general revenues and not split with the federal govenment as are intermediate and skilled nursing care costs (Heumann, *et al*, 1985). In New York, the Enriched Housing Program, which offers a core set of services to seniors in well-elderly apartment buildings, is classified as a Residential Care Facility, with the service package reimburseable through the state's SSI subsidy program which is funded from the state's general revenues.

The federal government may pay a major portion of costs in instances where congregate housing/services residents are very low income and are, therefore, eligible for federal SSI, federal rent subsidies, Title XX and other entitlement programs, or where congregate programs are granted Medicaid waivers.

Congregate housing is not cost saving if compared to other age segregated community-based housing/services alternatives or in-home care (Sherwood, 1986). Some argue, however, that any cost comparisons are misleading because too many confounding variables compromise results. For example, studies will use empirically based utilization patterns and cost estimates instead of actual data; use actual data for experimentals, but estimated data for controls; use no controls; use non-standardized definitions. Surveys will lack participant randomization, or will compare projects with dissimilar configurations of variables, residents or purposes. Research will cover short time periods; variables will not be held constant among programs. Resident charges vs. program costs are not always adequately identified, nor is the source of payment adequately distinguished or consistently factored in. Meaningful cost comparisons between congregate housing/services programs and in-home programs would have to take into account the mortgage and debt service costs of a private residence, repair and upkeep, utilities, food, transportation, and medical care (Pollack, 1976; Dellinger, 1975). Meaningful comparisons should be made without regard to who pays the bill and should include in-kind assistance by volunteers, family, and friends, and include lost opportunity costs. In addition, levels of client disability grossly affect the cost of community care, as does the quality of care delivered. Good care costs more than bad care, and cost studies do not deal directly with this issue (Lawton, 1978).

Thus, the issue of cost comparison is a murky one. What is clear, however, is that the number of older adults, particularly those 85+, will continue to increase into the next century, making present long term care alternatives inadequate for the number of frail elderly that will require shelter and services. Donahue (1981) estimated that three million semi-independent persons 65+ could benefit from congregate housing. Thus, any service program will create its own demand. Congregate housing/services is not a substitute for skilled nursing care. Institutionalization would not be averted, but a network of congregate and in-home programs would serve those who would not be candidates for institutions. In New York, with the current nursing home need methodology, nursing home beds will always be filled at their present full capacity with those elderly requiring the skilled nursing level of care; and congregate programs can continue to expand to serve the increasing number of older adults who will require assistance for continued independent living.

The argument for community-based and congregate services should not be to avert institutionalization, but to enhance the quality of life for a substantial segment of the older population, to serve as a preventive agent to the development of the mental depression commonly found among older elderly, (Lawton, 1978; Donahue, 1981), to augment the efforts of the growing number of families that constitute the vast informal support system currently in place to support semi-independent older adults, and to mediate the pressures felt by housing managers from the increasing demands placed upon them by the significant number of aging tenants with service needs.

Costs

- **Housing (rent and utilities) is the major cost of a congregate housing project.**
- **The consistency of demand for housekeeping services among congregate residents argues for cost efficiency in including this service in the monthly fees, while cost of meals should be offered at a per meal fee as meal service preference is so diverse.**
- **States have no refined methodology for determining the optimum resident number, case mix, or level of service to achieve cost efficiency, but thus far have based subsidy reimbursement on one or two demonstration sites or an average of service costs across the state.**

There is agreement in the industry that the major cost of congregate housing is the cost of the housing itself (for example, while the average of shelter and services per person in Massachusetts' state funded congregate housing program was $1,001.15 per month, housing represented $619.21, social and health services represented $239.26, and administrative costs represented $142.68). Beyond that agreement, research review and industry experience merely conclude that services are expensive and difficult to formulate into generalizable cost-efficient configurations. Cost analysis by Malozemoff's (1978) 27-site survey showed an association between financial stability of the project and the number of services included in the monthly fees, with sites providing the fewest services having the most positive financial status, and those with higher service levels almost uniformly operating at deficits, with food and medical services the most costly items.

In evaluating the Department of Housing and Urban Development's Congregate Housing Services Program, Nachison (1985) found that, dependent upon the number of residents, part-time staff was often sufficient to implement the program. The evaluation also found that the Congregate Housing Services Program must target service delivery on a "needs" philosophy and not a "wants" philosophy (that is, target those most at risk) in order to be cost efficient, that substituting program services for already existing community resources should be prohibited, that programs should focus on existing housing and use cost-sharing fee scales, and that groups of buildings in the same neighborhood achieve economic efficiency by sharing management, meal delivery, and in-home services.

Tell and Wallach (1984), in their study to determine cost variations among Continuing Care Retirement Communities, found that costs per resident had a systematic relationship to the proportion of residents in nursing care, location in a high wage or urban area, and the facility's tax status; and that while the impact of utilization-to-capacity was seen, the impact was quite small.

The service most used by congregate residents is homemaking/housekeeping. The consistency of demand for housekeeping argues for cost efficiency in including this service in monthly fees, while, as Malozemoff (1978) argues, since preference for meals is so diverse, cost of meals should be offered at a per meal fee.

Malozemoff, *et al.* (1978) found that the setting of monthly rates in any one project was not associated with the level of services provided, that after a minimal provision of services, cost increments of providing high rather than medium service is not significant. It is futile to think in terms of economies of scale in relation to a particular project because any one congregate project will usually be small in size, requiring the basic outlay required to operate any program. The benefits of utilization-to-capacity may be possible with multiple sites within a geographic area which would allow sharing of staff and equipment and permit larger service contracts. This arrangement may compromise quality control of service delivery and reduce staff/resident interaction. Human service industries must always contend with a variable which manufacturers need not consider; that is, maintaining a balance between cost efficiency and cost effectiveness. The most cost efficient human services program may not be the most appropriate for clients. While manufacturers strive for least cost per unit of identical output (efficiency), human service program operators strive to identify a program which will maximize service per unit cost in an *appropriate manner for clients* (that is, achieve the desired, often unmeasureable, outcome) relative to alternative *appropriate* programs (effectiveness).

According to Knapp (1978), one can determine how the costs of care will vary with the size of the home, the number of residents, dependency level of residents, and changes in resident well-being and behavior. Knapp states that the average cost curve of residential care services is U shaped; that is, cost per unit goes down as output increases and then rises again because of necessary increased administrative costs and the strain on the use of fixed equipment. Applying this to state-wide programs, determining the configuration of variables for each project's population within a geographic area will presumably determine the optimum size to be served for greatest cost effectiveness in that area. The difficulty here is that residents (units of output) are not static. Once the program is filled with residents determined to be a cost effective number and mix, the dependency variable will change continuously, affecting the cost of the program.

The difficulty in determining a cost effective formula is reflected in industry practice. The Malozemoff survey found that the development of service level was arrived at arbitrarily at 25 of the 27 sites surveyed, the operators offering what they thought "should be" provided rather than providing services based on a preliminary analysis of the target population and area costs. In a review of states' subsidized programs, initial cost parameters were set based on one or two small demonstration sites. Many of these states are now reviewing these spending caps because there is evidence they do not realistically reflect current costs.

Services

- Core package of services in traditional private congregate housing/services projects: one congregate meal, scheduled transportation, housekeeping, laundry, 24-hour emergency response.
- Core package of services in state-sponsored congregate programs: all of above plus social services and personal care services.
- Congregate services programs do not include chronic nursing care.
- Congregate project service used most by residents: homemaking/housekeeping.
- Publicly subsidized congregate programs often mandate no duplication of existing community services.
- Number and intensity of services available in a program reflect management's view of elderly persons as independent/dependent and defines the population to be targeted.
- Service delivery by project staff vs. contracted providers is a function of rural/suburban/urban location, with close proximity to community services associated with increased use of contracted providers.
- The overwhelming majority of congregate housing/services program residents do not relocate to institutions, but remain in the congregate facility until death.

Laws vary from state to state regarding the provision of medical services and licensure. In New York, private congregate housing/services projects do not require licensing as long as the operator does not directly provide personal care or health related services or does not include the cost of personal care services in the residents' monthly charges. The operator may assist a resident in contracting individually for health services through a private physician, hospital, clinic or home health agency. A sponsor may even locate a congregate housing/services project on the same campus site with a medical clinic, nursing home, or hospital and have arrangements with these facilities to care for the congregate residents. An operator may have an RN on staff for emergency intervention. However, if the congregate project's staff directly provides hands-on personal care services or if the personal care component is included in the monthly fee as part of the service package, the project must be licensed and regulated as an Adult Residential Care Facility (Adult Home) by the New York State Department of Social Services. Confusion between adult homes and congregate services projects arises because the range of residents' functional profiles in both types of facilities are the same. The range of services available are also the same. The methods of service delivery and resident payment for personal care services distinguish the two. Thus, New York's Enriched Housing Programs, which provide personal care service and include the cost for this service in the residents' monthly charges, are licensed by the New York State Department of Social Services as Residential Care Facilities.

The core package of services in congregate housing/services facilities includes one congregate meal a day, scheduled transportation, housekeeping, laundry, and 24-hour emergency response. In private proprietary congregate housing projects, the number of meals, hours of housekeeping, mode and flexibility of transportation, and diversity of recreational activities vary from project to project; and this diversity is reflected in the monthly fees charged to residents. The configuration of services also reflects the project's management philosophy. If a sponsor views the elderly as healthy, independent individuals, he may offer only one congregate meal, make that meal optional, limit transportation to emergency situations, refer to housekeeping as maid service, encourage active recreational activities, and take no part in brokering in-home care for residents. This sponsor may feel that impaired elderly detract from the project's marketability; and eligibility for entrance will be restricted to younger, healthy, very mobile older adults who view the services as a convenience and who move to a congregate project for the social benefits or to escape the burdens of home ownership. These sponsors, and the project's residents, may be adamant about residents leaving when impairment compromises independence.

Older non-profit projects that began with a similar view have witnessed the gradual impairment of their residents who have aged in place and who are reluctant to move. Managers in these facilities have gradually increased and added services to accommodate the changing profile of their residents. Additional congregate meals and transportation are provided, and personal care is made available through a management contract with a community home health agency, or brokered by management on behalf of individual residents through various community agencies. Some projects maintain an RN on staff for emergency, intermittant nursing care or crisis intervention. A social worker may provide case management, counseling, and coordination of social activities.

Malozemoff's (1978) nationwide survey of congregate facilities found 59 per cent offering personal care services and 41 per cent offering no personal care. Proprietary facilities will stop short of allowing on-going in-home nursing care, as continued nursing care changes the character of the project.

Public congregate housing/services programs, because they are publicly subsidized, target frail, at-risk, low income elderly. Congregate meals, transportation, housekeeping and 24-hour emergency response are provided, but social services and personal care services are also an integral component of the core service package since mental or physical functional eligibility criteria for admittance to the programs mandate that residents require a certain level of assistance with activities of daily living. Financial eligibility criteria for subsidies require that residents be below a specific income ceiling, and this dictates that another required service of public programs be assistance in accessing other eligibility programs in the community such as food stamps, medicaid, SSI, Title XX, etc.

State and federal subsidized programs are very careful to mandate that congregate programs not provide overlapping or duplicative services but, rather, act as a supplement to fill gaps in services and coordinate the delivery of existing services. New York's Enriched Housing Program is atypical in providing a congregate services program which provides the core services, including personal care, and utilizes other existing programs as a supplement to the congregate program.

The services of a congregate program are such that very few public and non-profit congregate residents move to a nursing home. A few move back with families, and a few move to acute care hospitals and subsequently die there, but the overwhelming majority remain in the congregate facility until death.

Congregate housing projects supply their own staffed services in direct proportion to distance from community services. Urban sites rely on the community for provision of services to a greater degree than suburban sites, with rural sites (greatest distance from available services) utilizing the lowest proportion of community services.

There is a relationship between accessibility to community services and management's attitude about the target population's independence (Malozemoff, 1978). Operators who strive to continue residents' independence will locate within walking distance to services or near convenient transportation. Location is less of an issue for operators who feel the population is dependent because management assumes the responsibility for provision of necessary services. Transportation, at varying levels, is provided in all state subsidized programs since the need for transportation assistance is characteristic of the targeted frail populations in those programs.

The formal service most used by congregate program residents is homemaking/housekeeping (Mass. Final Report, 1984). Residents view housekeeping as an essential service and use this service to the maximum, purchasing it independently if not available through the program; the demand for housekeeping is stable and constant across sites (Urban Systems, 1978). There is no consistent association between resident income level and use of housekeeping.

Program staff hired specifically for the congregate program participants develop a personalized relationship with the group as a whole, see them on a daily basis, become prime movers of group activities, and become an intimate part of congregate life. Staff hired through sub-contract and assigned to individuals are less involved with group life and do not consider residents' interrelationships to be of professional concern (Mass. Final Report, 1984).

Discussions with project managers indicate that a growing problem is emerging regarding the home health industry. Demand for home health, personal care and homemaker aides has outstripped supply, resulting in problems in service availability, quality control, and staff consistency. In some areas, the local political situation dictates agencies' service turf, leaving consumers with little choice. In an effort to resolve these problems, one congregate operator is contracting with a home health agency to locate an office within the congregate facility and assign a constant group of aides to the facility's residents.

Meal Program

- **Congregate programs provide congregate meals several ways: prepared on site by program staff, use of Older Americans Act Nutrition Site Programs, contracted with commercial food services, and contracted with local institutions.**
- **For the congregate program payor, the least expensive method of delivering meal service is to designate the facility an OAA Nutrition Site (federally subsidized meals).**
- **Survey results on best methods for providing and serving meals are inconclusive.**
- **A review of the literature finds conflicting research results regarding older adults' preferences about meals.**
- **Many variables affect patterns of congregate meal use: age, agility, sex, marital status, ethnicity, income, quality of service.**
- **There is policy mismatch between program developers and gerontologists on one hand who see social and nutritional benefit to congregate meals, and the elderly themselves on the other hand who prefer cooking and eating in their own kitchens until age and impairment make this activity impossible.**

It is difficult to categorize patterns of meal use because many variables affect usage, and a review of the literature and discussions with program managers find conflicting conclusions regarding the preferences of older adults.

Different eating alternatives are preferred by residents as changes occur in age, health status, and physical agility. Increased age and decreased agility bring an increase in the proportion of residents who use the congregate meal program exclusively and bring an increase in the proportion who eat with family and friends. However, Malozemoff's (1978) survey found a distinction between agility and health status, with no association reported between declining health status and increased use of meal programs. It is thought that decreased health status brings an overall disinterest in eating. Single men are more apt to use the meal program, as a convenience. A greater proportion of couples cook for themselves in place of congregate meal service. The greater majority of older adults prefer taking the main meal of the day in the congregate hall, which can be either lunch or dinner; most do not eat an actual breakfast, preferring coffe/tea and a muffin/toast. New entrants to a facility use the common meal to make friends; continued use of the congregate meal as a social function decreases as the resident establishes a social network.

Income levels affect meal program usage. Low income elderly cannot afford restaurant visits, and their use of discretionary funds is directly affected by the inclusion of meal costs in monthly charges. For these persons, preferences cannot be exercised. However, in Prosper's (1985) survey of the Continuing Care Retirement Community industry, where residents had enough discretionary income to exercise eating options, there was a definite trend to including only one congregate meal a day in the monthly charge.

While some sites find younger, agile residents preferring their own kitchens and eating in restaurants, others find that younger, agile residents use the meal program as a convenience in order to increase the amount of free time available for leisure activities. Powell Lawton's research (Thompson & Donahue, 1980) showed that residents wished to make their own meals in their own apartments and would not necessarily be regular program customers if participation in the meal service were optional. On the other hand, the International Center for Social Gerontology (1978) found that "...experience indicates that tenants who do not need the meal service will avail themselves of it as a convenience and will pay the full cost."

The quality of the food, the elegance of the service, the environment of the dining hall, and the desire for ethnic foods affect usage of the meal program. The health status of the facility's resident population also has an impact. Managers find it takes a great educational process to achieve the acceptance of highly impaired residents in the dining room by those who are less impaired. Other managers consciously segregate diners by functional ability.

The Malozemoff (1978) survey found that availability of meals was not a significant determinant in residents' decisions to choose a congregate facility. Generally, residents viewed the on-site meal service attractive as a convenience, but not as an essential service. However, once in the facility, 72.5 per cent of the surveyed residents used the meal service once a day or more; and, in general, Malozemoff found a preference for a two-meal per day program. A significant proportion of residents defaulted on at least one meal per day at sites requiring three meals a day, but some residents were purchasing additional meals at sites requiring only one meal a day. However, in discussing HUD's required two congregate meals a day in its Congregate Housing/Services Program, researchers state that this could be reduced to one daily meal without hurting residents (Housing the Elderly, 1985; Bokser, 1986). In response to the program's evaluation results, HUD intends to change its CHSP requirement of two congregate meals a day to one meal a day, with resident option to take more than one congregate meal.

The Department of Housing and Urban Development's 1970 congregate housing initiative allowed the construction of congregate facilities with or without private kitchen facilities (but including central kitchen facilities) and, therefore, mandated that residents take two congregate meals. Recently, HUD was subject to lawsuits by Section 202 facility residents who objected to the mandated 14 meals a week requirement, and HUD recently changed its regulations to prohibit mandatory meals in any new Sections 202 and 221 facilities and Section 8 programs, but will allow any currently existing mandated meals programs in existing facilities to continue (Harris, 1986; Nachison, 1987).

A review of the literature also finds disagreement as to which daily meal is preferred to be taken in the congregate setting. According to Donahue and Thompson (1980), experience indicates that the congregate meal is preferred in the evening by most residents. However, some projects offer the congregate meal at mid day based on residents' expressed preference. As people get older, many shift the major meal of the day to noon time because of declining ability to digest a heavier meal in the evening and the interference this causes with sleeping patterns.

There is a relationship between the number of meals in the program and management's attitude regarding the dependence of the residents they are trying to attract (Malozemoff, 1978), but there is not always congruence between the intended target population and the resident group actually admitted. Irregular patterns of meal usage and changing preferences with changing resident profiles argue strongly for flexibility and choice in providing meals in congregate programs.

There is agreement that meal service is by far the most costly component of any congregate service program. Two mandated meals a day, seven days a week, accounted for 54 per cent of HUD's program costs. Meals accounted for 34 per cent of service costs in Connecticut's congregate housing projects. In the Malozemoff survey, meals were 53.9 per cent of "medium service" facilities and 48.2 per cent of "high service" facilities. In Heumann's (1985) analysis of seven congregate facilities in Illinois, food service accounted for an average of 33.5 per cent of total expenses, with food costs in two facilities providing 20 meals per month accounting for 25 per cent and 31 per cent of total expense, one facility providing 25 meals per month averaging 30.5 per cent on food service, one facility providing 52 meals averaging 30 per cent, two facilities providing 60 meals per month averaging 41 and 46.5 per cent, and food costs in one facility providing 90 meals per month accounting for 32 per cent of total costs. Beyond that agreement, there is conflicting data and opinion regarding other aspects of meal service cost. The configuration of paid/volunteer/part-time/professional/unionized staff, facility location, number served, utilization of other community services, resident profile, delivery method, and menu make-up uniquely affect each project's total meal cost.

Personnel is a major component of the meal cost. A greater proportion of residents requiring assistance in eating, special diets, tray service, and assistance in getting to and from the dining hall will have an impact upon the number of staff required. Less menu choices and menu changes and cafeteria style service instead of family style would require less staff time, as would less elegance in table cloths, silverware and table decorations used.

If the residents are completely self-ambulatory, the per unit cost of a meal does not fluctuate greatly with the addition of more residents until the number increases enough to require adding to the basic staff.

Malozemoff, *et al*, (1978) tabulated unit costs of meals against volume ranging from 50,000 meals served per year to sites serving 300,000 to 350,000 meals per year. They found only a weak tendency for lower costs at higher volume. The heavy staff costs of meal services allow for low marginal cost per meal relative to average cost per meal. Sites could shift volume significantly without affecting unit costs, except for raw food costs. However, that analysis may hold true only when dealing with very high numbers and may not be applicable to congregate programs which operate in discrete locations with small numbers of residents.

For small operations, a critical cost element is the degree of utilization at which a project is operating relative to the project's total capacity to operate. Any size program requires an initial outlay for fixed costs (equipment and space, etc.) and a minimum number of personnel (cook, servers, cleanup, etc.). As the number of residents served increases, approaching a project's capacity to serve those residents without requiring an increase in fixed costs and personnel, the per unit cost of the meal service will decrease. Very small congregate projects do not operate at capacity and, hence, do not operate cost efficiently. Opening a congregate project's meal service to non-program participants would allow a program to operate at capacity, as would sharing staff, equipment, and food purchasing between several projects within a geographic area.

The Department of Housing and Urban Development's Congregate Housing and Services Program found that a significant number of their participants were assessed as not "needing" two congregate setting meals. Mandating that the program include 14 congregate meals a week for all program participants cost HUD for congregate meals which many participants did not "need." The CHSP evaluation suggested that congregate meals should go only to those whose functional level requires them. However, providing congregate meals for a limited number of persons raises the utilization/capacity question for small projects. A survey of Continuing Care Retirement Communities supports this concern. Prosper (1985) found that CCRC operators found most residents wanting only one congregate meal per day and operators finding it economically unfeasible to provide a second and third meal for only a quarter of their residents. Lawton (Thompson & Donahue, 1980) suggests that making all meals mandatory would screen out application by relatively healthy people, thus overloading the resident population with impaired persons Very few programs require participants to pay for all three daily meals. A common practice, to promote financial feasibility and to respond to residents' preferences, is to require residents to pay for a certain number of meals per week or month, then requiring advance notice from residents of which meals they will attend.

Meals are provided by a variety of methods. The most economical method *for the congregate program payor* is designation of the congregate housing facility as an Older Americans Act Title III-C community nutrition program meal site because that program is underwritten by the federal government. When that is not possible, projects will have meals catered to the project from a nearby OAA site, or purchase meals from a commercial food service or from a community institution such as a hospital which is already preparing meals in bulk, or purchase and prepare food on site utilizing the project's staff. Two of Connecticut's congregate projects which provided one meal per day through the OAA Title III-C program averaged a monthly meal cost of $89 per person compared to a third project's average monthly meal cost of $110 per person which did not use the Title III-C program.

There is disagreement about cost comparison of site-staff preparation vs. contracted food service. Nachison (1985) uses the Ruchlin and Morris study to say that where projects hire staff rather than contract for services, savings have been substantial. On the other hand, Malozemoff, Anderson and Rosenbaum (1978) surveyed 27 sites and found that 19 provided 13-21 meals per week and 3 provided 6-12 meals per week. Sixteen sites reported unit costs: ten prepared meals in-house (including four which were Title III meal sites) at a unit cost of $.71 to $2.04; six contracted out for meal service at a unit cost of $1.04 to $1.97. The average cost of in- house/contracted meals was $1.31/$1.29.

Heumann (1985), for comparison purposes in his survey of seven congregate facilities, translated congregate meal costs for each facility into 90-meal-per-month programs and found on-site food service per resident per month for four sites ranged from $209 to $234, while two facilities with combination caterer/on-site service cost $174 and $224, and one facility with a for-profit catered service cost $199. However, factors complicating the comparison include: cafeteria vs. restaurant style service, differences in the number of entrees, choice of portions, and number of residents in each facility.

The question of site-staff preparation vs. catered meals via the Nutrition Program or similar sources is also a subjective quality-of-life issue. Purchasing, preparing, and serving meals by the project's own staff provides meals by someone who comes to know the food likes and dislikes of the resident population. Staff can also incorporate ethnic diversity, include resident input into menu items and flexibility into meal times, and accommodate creativity in planning. Thompson (1980) compared a $2 catered meal with a $2 site-prepared meal. For the same price, the site-prepared meal included 15 choices within six categories vs. the catered meal's five choices within five categories. Thompson suggests that the outlook of a continuous diet of the average catered meal year in and year out is dismal. Nachison (1987) counters that the crucial variable is quality of the caterer, saying that the HUD Congregate Housing and Services Program's experience with caterers has been generally positive because the quality of the food service vendor has been good.

Of the two principal types of meal service, cafeteria style service may be cheaper than family style service because it decreases staff costs and, at the same time, may provide a wider range of choice in food selection (Thompson & Donahue, 1980). However, the decision on service style depends on the functional characteristics of the residents and the availability of volunteer staff to reduce costs. Some residents may not be able to handle a tray in addition to a mobility aid; certain degrees or types of frailty may cause apprehension and spillage; those in wheel chairs may not be able to see or reach the food, requiring dependence on others that would not be necessary if seated for service.

Tray service (delivering meals to a resident's room) is an expensive item, requiring more staff time, and is generally offered only for temporary periods of time and on a doctor's orders.

Kitchens

- **Women residents prefer to have a private kitchen.**
- **Kitchens are not an issue for widowed men.**
- **Kitchens become less of an issue for residents who are 85+ and very impaired.**
- **Kitchens and larger sized units are important to lower income residents as they serve as their center for social activity.**
- **Kitchens serve to maintain residents' independence and privacy.**
- **Occupancy is hard to maintain in units with no kitchens.**

Both the congregate housing/services industry and its more affluent version, the Continuing Care Retirement Community industry, learned through experience that older adults prefer to retain their kitchens as a component of their living units and, until impaired, prefer to eat in their own apartments. Eighty nine per cent of Thompson's (1975) survey of senior housing residents recommended individual kitchens.

Residents use kitchens to prepare snacks, prepare breakfast and/or lunch, cook for friends and family, maintain a private stock of food, cook ethnic or religious meals, and cook meals "their own way" (Thompson, 1980). Even residents who do not have a refrigerator or eating utensils in their rooms have a shelf or table for snacks, and almost all residents entertain family and friends in their own rooms rather than in common spaces (Mass. Final Report, 1984). The great majority of congregate housing residents are women, and managers find that women want a full kitchen. However, most male congregate residents have never cooked for themselves and do not consider the kitchen issue an important one. Younger elderly want a kitchen; for those 85+ who suffer from chronic or severe impairment, the congregate meal service becomes more attractive and the kitchen is less useful.

Congregate housing is described as an elderly housing alternative, not a level of institutional care. Institutions are defined in terms of "beds," while congregate housing is defined in terms of independent living units. The home-like environment (which includes a kitchen) of a congregate housing/services project is one of its great advantages over an institutional setting. The availability of kitchens enhances the flexibility and control of one's life because congregate meals, whether in congregate housing or institutions, dictate when, what, and with whom one eats. Elimination of the personal kitchen shifts the character of the living environment from home-like to institutional. It removes a component which symbolizes, and in reality is, a source of independence, and one which is critical for maintaining a sense of privacy.

A common complaint about shared apartments centers on the kitchen turf issue: which food belongs to whom, equal division of shelf space, compromises on use-time, dissatisfaction over sharing of cleaning chores. Turf is not as much an issue in a group family residence as the kitchen is acknowledged as belonging to the family group. However, in a two-person shared apartment, the initial occupant establishes ownership of the kitchen.

The Malozemoff (1978) survey of congregate-type facilities found a direct relationship between the provision of kitchens and management's targeted population (perceived frailty/dependence). Managements' perceptions, however, have not always matched residents' preferences. Many Continuing Care Retirement Communities that began with kitchinettes have replaced them with full kitchens to satisfy resident complaints and to enhance marketability. The trend in newer state-supported congregate projects is to include full kitchens. Of 15 state-supported congregate housing/services programs reviewed for this report, ten had private kitchens, three had family kitchens in shared-living family homes, and two included no kitchens.

Some facilities have a "Pullman-type" Kitchen in each living unit. This is a combination unit consisting of two burners and a sink over a refrigerator, and a detached cupboard above the unit. This is installed in a closet-sized area. Aside from the small size, it is difficult for many elderly to bend down to retrieve items from the refrigerator, and this often requires getting down on one's knees. Also, there is a safety issue involved as there is no drainboard and the stove burners are three or four inches away from the sink; and residents (who may be frail) often use stools to reach items in the overhead cupboard.

A related issue is seen regarding the size of living units. One- and two-bedroom units are preferred over efficiency apartments. Most projects have waiting lists for larger units, but studios remain vacant even in areas where people need housing. Contrary to what may seem logical, lower income residents place greater importance upon larger units than higher income residents. One manager explained that low income persons used their homes as the center of their social lives since they could not afford activities outside the home. Reducing the size of their living space and eliminating kitchens reduced their "living" space.

If required to choose, congregate housing residents preferred a private kitchen over a private bathroom, and preferred a private toilet over a private shower or tub (Urban Systems, 1978; Welch, *et al*, 1984). Some residents prefer a shower because it is easier to get in and out, so a tub with a shower is not the answer. Other residents prefer a bathtub for soaking, or for medical or other reasons.

Advantages and Disadvantages

- **The congregate housing/services concept provides an "accommodating" rather than a "constant" living environment: it flexibly meets the changing needs of residents.**
- **The congregate housing/services concept is a viable alternative to bridge the gap between the extremes of complete self-sufficiency and the custodial care of an institution.**
- **There is inherent financial incentive to provide minimum therapeutic intervention and to maximize preventive care, which promotes resident independence and counters resident assumption of the "patient mode" common in institutional facilities.**
- **Congregate programs enhance the quality of life for older adults.**
- **Segregating congregate program residents by functional ability may result in the establishment of additional levels of institutionalized care.**
- **The character of living environments are often defined by public funding policies; these policies can promote segregation by abilities, or can create incentives for mainstreaming older adults into integrated environments.**
- **To maintain market appeal, contain costs, and mirror life in the general community, congregate housing/services projects should maintain a resident population mix of ages and functional abilities.**

Estimates indicate that between one and three million older adults would presently benefit from housing with integral services (Sherwood and Bernstein, 1985; Urban Systems, 1976; Donahue, 1981). For the great proportion of older persons who are female, single/widowed, lonely, over-housed, and have low income, a congregate living environment provides the emotional and financial security inherent in 24-hour emergency response and the available and affordable services and shelter.

Research has shown that loss of a confidant is a major factor in depression among the elderly and simply increasing social activity in place of this loss does not counter depression (Lowenthal & Haven, 1968). However, group activities and living in close proximity to others who are similar in age and life status create a fertile environment for developing close friendships and replacing lost confidants.

Lawton describes congregate housing as an "accommodating" environment (Sherman, 1985). It can change to accommodate the evolving needs of its residents, in contrast to a "constant" environment which is not flexible, but requires residents to move when their needs change beyond the capability of the environment to meet those needs.

When their environment is a viable one, older adults prefer to age where they are (Ward, 1984; Sherman, 1985; Shanas, 1968; Lawton, 1978); and involuntary relocation has negative affects on older adults' physical and mental conditions (Hiatt, 1977; Borup, 1979; Lieberman and Tobin, 1983). The accommodating environment of a congregate housing/services facility allows older persons to age-in-place, with coordinated health, social, and recreational services available and easily accessible. In contrast, because of the licensing and regulatory requirements, institutional facilities do not include as much variability in design and management as does congregate housing/services projects; and the institution's staff, not the residents, control the types and timing of most social events and basic activities of daily living (Heumann, *et al.* 1985).

The congregate housing/services concept can meet a spectrum of demands and is compatible with a variety of lifestyles. Its services are a convenience for active, mobile older adults and are support provisions for those with lesser physical capabilities. Contrary to institutional living, residents are not obligated to use the services, but, instead, have choices as to which services they will use and at what level of intensity they will use those chosen services. The congregate concept provides a living alternative which fulfills Lawton's Adaptation Model of environment which purports that an individual at a given level of competence will be optimally adjusted at a given level of environmental demand (Sherman, 1985).

Policy makers express concern that easily accessible services will result in increased use of those services. There appears to be no relationship between availability of services and increased usage (Zimbalist, 1980; Tell and Wallack, 1984; Winklevoss and Powell, 1984). Malozemoff (1978) found that utilization of medical services among the majority of residents surveyed was extremely low, and a considerable number continued to see and pay for their own doctors in the community even if the congregate facility's physician services were included in the monthly charge. There is a financial incentive for managers of a congregate program to keep health service usage to a minimum and to utilize preventive services as a cost containment measure and to enhance the program's marketability. Publicly subsidized programs use professional assessment committees (PACs) to individually assess clients for needed services. The incentive for preventive services is applauded by gerontologists whose research has shown that minimum service intervention promotes a person's sense of independence and counters the assumption of the dependent "patient mode" that occurs in medical model environments such as acute care hospitals and nursing homes which routinely provide intensive service.

Congregate housing/services programs are emerging as the viable alternative to fill the growing gap in services resulting from the policy changes in reimbursement systems for acute care and skilled nursing (Diagnostically Related Groupings Prospective Payment System and the Resource Utilization Groupings System). Congregate programs provide a wide range of assistance to allow for the longer and more intensive at-home recuperation time following illnesses and provides an affordable assisted environment for those elderly who no longer meet the "heavy-care" eligibility criteria for skilled nursing.

Lack of access to community services and social events is a cause of reduced involvement and activity among older adults living in the general community (Urban Systems, 1978). Accessing these community functions and services requires planning, transportation, and a certain level of mobility. The availability of on-site or brokered services in a congregate housing/services project alleviates the problem of access. As congregate residents' activity in the general community declined because of age and health status, activity within the congregate community was prolonged beyond the point when it would naturally have begun to decline (Urban Systems, 1978). Malozemoff (1978) concurs, finding off-site participation a function of age, health status, and accessibility, while finding health status the only variable to have a consistent effect on reducing the level of activity within a congregate program. Participation in programs and activities increased in number and frequency among congregate residents of all age and income groups compared to their previous participation while in the general community. Residents' new relationships within the facility did not replace previous relationships, and residents' interactions with family members remained the same or increased.

Most congregate projects will claim a reduction in institutional placement, reduced use of acute facilities, and an increase in quality of life; but surveys often do not make reliable comparisons, so conclusions are difficult to draw. Also, results of surveys are not consistent enough to be generalizable from project to project because the unique character of each project affects outcome. Sherwood (1985) found that the Department of Housing and Urban Development's Congregate Housing and Services Program intervention, after 30 months, had no impact on death rates comparing program participants and matched controls. However, the HUD program population, while vulnerable, was not a severely impaired one. In comparison, Sherwood's (1981) evaluation of the Highland Heights medical congregate project (where participants required intensive service) showed that during the first four years program participants were significantly less likely to die than control members (who were applicants to Highland Heights and, thus, similarly impaired).

In a study of 78 older adults moving into a congregate facility and 122 moving into a traditional housing facility (no services) (Sproat, 1976), tenants in the traditional facility increased or maintained their involvement with the general community and in their use of leisure activities, while congregate residents showed no increase in general community involvement, but did show improvement in morale, housing satisfaction, and loner status.

Residents of an Intermediate Housing project (non-medical services) experienced overall satisfaction with living arrangements compared to their previous location and had increased enjoyment of life and social contacts compared to controls who had applied to the project but did not enter (Brody, 1975). Sherwood, *et al*, (1985), in comparison studies of nursing home/geriatric day hospital, nursing home/senior center, and senior center/geriatric day hospital, found no overwhelming differential quality of life effects emerge after nine months of placement (quality of life: satisfaction with life, personal adjustment, psychological dependency, reality orientation, anxiety, and hostility). However, the researchers found that a more qualitative analysis suggested that clients served in less restrictive environments appeared to do better with independent living skills.

Lawton (1976; 1980), in comparing the effects of congregate housing and traditional housing on elderly tenants, found congregate housing tenants showed improvements in morale, housing satisfaction, socialization opportunity, and loner status, but decreases in involvement with the external community relative to traditional housing tenants.

A potential disadvantage of congregate programming is the segregation of older adults by age and functional level. Construction of facilities expressly for residents who meet functional impairment criteria may be isolating a categorized group of elderly into another level of institutionalized care, obviating its residential character. For example, Washington State's program, which subsidizes services to residents in homes serving 3 - 400 persons, refers to its facilities as having an average of 20 "beds." Similarly, increasing the percentage of residents in a senior housing project who receive service assistance may result in changing the character of the building from residential to institutional. Five states surveyed, who provide congregate services in existing senior housing, limit the program to between 20 and 30 per cent of the building to avoid compromising the integrated environment.

Separating populations by age, and then by abilities, fosters stereotyping and misconceptions about aging and disease. However, co-mingling older people of varying abilities has few advocates, even among the elderly themselves. Some funding sources, particularly SSI and medicaid, exert pressure to form policies and programs which create rigorously differentiated levels of care by giving financial incentive for segregation. In the 1980's the trend toward subsidies for in-home care and block grants to support congregate programs provides an opportunity to develop programs which will respond flexibly to aging as a variable process rather than a fixed category of abilities (Hiatt, 1977). Funding policies can promote integrated programming and provide incentives for innovative mainstreaming of older adults.

A congregate facility will mirror the characteristics of the community in which it is located. For example, the population of one urban congregate housing/services project in Connecticut is a mix of low-income Black, White, and Hispanic. The management was having great difficulty in getting these three groups to interact. However, their difficulties reflected the distrust among these three population groups in the low socio-economic area from which this facility drew its residents. There was very little congregate resident interaction with the surrounding community, and residents were afraid to walk outside. Gardening could not be done because "if we planted tomatoes, someone would steal them." This facility could not count on community volunteers as a means of cost reduction or increased staff/resident ratio. In contrast, another Connecticut site was located in a rehabilitated elementary school in a middle class suburb. The school had been a focal point for the community's children and subsequently became accepted as an integral part of the community for its older adults. There was continuous interaction between the facility and community individuals and organizations. For example, boy scouts assisted residents in gardening, and Little League games continued on the facility's grounds with congregate facility residents selling hot dogs at the games.

A high-rise may appear as an old age institution in a suburb or rural area, but be a welcome, new housing alternative and a status symbol in an urban area. One "Yankee" town viewed "shared living" as an admission of failure. Mistrust, tension, or competition between service organizations in a community may translate into disputes between those groups and/or the managers about who is responsible for providing services, resulting in non-cooperation or even gaps in service. Costs and methods of delivery are affected differently in service rich and service poor areas.

A common argument against the congregate housing/services concept is that projects take longer to achieve 100 per cent occupancy than do conventional housing projects. Often managers cannot use a traditional first come, first served basis for choosing from the waiting list, but must select residents appropriate to congregate living (Mass. Final Report, 1984). Also, government sponsored programs may dictate who can fill a vacated apartment; for example, requiring that studios be rented only to individuals and one-bedroom apartments be rented only to couples. In order to keep market appeal and maintain a resident group that stays within feasible service (and cost) boundaries, a population mix of ages and functional levels must be maintained in order that a continuing proportion of residents die and be replaced by younger, less impaired occupants instead of an entire group aging together and eventually placing a cost and service strain on the facility.

Tenants must be selected in such a way that the number of residents dying over a five-year period equals the number of residents in the youngest age group, and replacements are always made to the youngest group (Thompson and Donahue, 1980). Suggested formulas include: (1) Ten per cent aged 62-68, 80 per cent 69-74, ten per cent 75+; or (2) 75 per cent residents who may need only the meal service or who suffer only social or psychological impairment, but can otherwise care for all other activities of daily living; 20 per cent residents who will need both the food program and housekeeping and some help witih ADLs;

and five per cent residents who are frail and require all of the services all of the time (International Center for Gerontology, 1978).

Use of such formulas increases in significance as the effects of the aging-in phenomenon are seen across the country. This phenomenon has had an impact upon the administrators managing senior housing, the service program providers, and the residents themselves. In senior housing buildings with no service programs, housing managers whose duties were traditionally confined to "housing-related" concerns are finding that 50 per cent or more of their time is spent in responding to the personal needs of their residents; and the two biggest concerns of these managers are "residents' health" and "the ability of residents to care for themselves" (Housing the Elderly, 1987; Wisconsin Survey Research Lab., 1986). In buildings where services are available, program providers are finding that increasing longevity and availability of intensive in-home care from private vendors are combining to result in increasing numbers of residents who are no longer appropriate for private apartment living, but who exercise their first choice to age-in-place and whose families resist relocation of their older members because of the impoverishing costs of institutional care. As the number of residents in senior housing who require assistance increases, fear among unimpaired residents grows that the character of their living environment will change to resemble a nursing home.

This situation has highlighted a looming major policy debate; that is, the issue of discharge: to what extent should intensive services be provided in order to continue to maintain residents in their own apartments; what are appropriate discharge policies; can discharge policies be enforced (and what are the legal implications for housing managers, service providers, and residents); and who should make the relocation decision. Philosophies vary among both housing managers and service providers, with some feeling that the "well-elderly" image of a building should not be compromised, and others feeling that residents should be permitted to remain in their apartments as long as services can maintain them. The attitudes of residents are often a function of the aging process, with younger and unimpaired elderly opposing the presence of impaired residents, wheel chairs, nursing staff, etc., but finding their attitudes softening as they themselves require services.

The average age of residents in traditional senior housing and in congregate housing has increased, as has the average age of those on the waiting lists, who then fill vacancies at older ages. A consequence of this has been a gradual shift in attitude among younger well-elderly persons in the general community to delay moving into these buildings until they are older (late 70's) and feel an impending need for assistance. A second consequence is a sharp decrease in the amount of time elapsing between residents' entry into senior housing facilities and the need for supportive assistance. Managers of new facilities are finding a significant number of residents requiring supportive services within 18 months to three years following initial rent-up of the building. A third consequence is adamance on the part of some housing managers that residents leave as soon as impairment compromises their independence in order to maintain the marketability of the housing facility. A fourth consequence is the recognition among developers that the 80+ population represents a growing housing market for the development of "assisted living" facilities, with the marketing of these facilities to those older adults who require assistance upon entry.

These trends may result in the increased segregation of "well elderly" and "impaired elderly" and result in the addition of another constant-environment/level-of-care rather than the promotion of in-home-service/residential-environments for mixed case populations which reduce need for relocation and which imitate life in the general community.

Conclusion

Appropriate housing and service alternatives are needed to accommodate the varied needs and preferences of the growing number of older persons. The congregate housing/services concept is one alternative which can flexibly meet the needs of older adults as they change over time. The availability of appropriate and affordable shelter and supportive services extends the period of time that older persons can maintain an independent life style, and the social aspects of a congregate program act as a preventive agent to the development of the type of mental depression commonly found among elderly people.

On a case basis, for nursing-home-eligible individuals assessed as requiring "light-care," congregate housing is cost effective relative to nursing home care. As New York's Resource Utilization Groupings reimbursement mechanism for skilled nursing facilities is implemented in states across the country, more stringent entry criteria for nursing home admittance will result in a more efficient use of Medicaid dollars as beds are filled with only those patients requiring "heavy-care," but will leave a service gap for those requiring a sheltered environment but requiring less intensive care.

Thus, while some argue for the development of congregate housing based on the cost differential between congregate housing and skilled nursing facilities, congregate housing/services programs should not be considered a substitute for nursing homes. As the number of frail elderly (85+) increases, the need for nursing home care for individuals requiring "heavy-care" will continue to increase, and congregate housing/services should be considered an additional option of community-based services in the continuum of appropriate support necessary during the later years. Because of its flexibility in providing only that level of services required on an individual basis, congregate housing/services programs successfully bridge the wide range of needs between the extremes of total self-sufficiency and the custodial care of an institution.

It is tempting to try to identify one best congregate concept model and a most cost effective method of service delivery within that model. However, as is evidenced by the diversity of program variations in place across the nation, there is no one model or delivery method which can be deemed the best path to follow in providing community-based services. The inherent complexity of variables within these programs make cost comparisons among them inconclusive. However, this very difficulty which prevents arriving at a definitive model may be serendipitous. Of all the age groups, the elderly are the most diverse in terms of needs and preferences. Successful development of appropriate living alternatives for this group depends upon providing maximum choice along the continuum between housing with no services and shelter with the highest level of services. The major advantage of the congregate housing/services concept is its capability of being implemented in many variations to take advantage of the unique conditions and characteristics of each locale and to utilize the creativity of sponsors and staff to cost effectively adapt the program to individual residents rather than mold participants to fit a static model.

The current lack of a sufficient number of appropriate housing units for older adults in New York has resulted in extremely low vacancy rates in senior housing, long waiting lists, and an increase in average resident age as both residents and waiting-list applicants age in place. As the movement to develop more senior housing grows in public and private sectors in response to identified need and market demand, policy makers must guide this development to avoid what may be the easier route for developers: creating housing models which segregate older adults by functional profile and which will result in several levels-of-care rather than promoting integrated, flexibly supportive, residential environments.

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METROPOLITAN COUNCIL *Mears Park Centre, 230 East Fifth Street, St. Paul, MN 55101 612 291-6359*

July 7, 1989

Hon. Edward R. Roybal, Chair
Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20515

RE: Hearing on Housing for the Frail Elderly

Dear Representative Roybal,

I am very glad to hear that you are accepting written testimony on the topic of the changing needs of elderly persons who are residents of publicly subsidized housing.

This is, indeed, an important issue for us. In the late 1960's and early 1970's, a great deal of publicly subsidized housing for elderly was built in the Twin Cities Metropolitan Area in Minnesota. At the present time, over 11% of the population age 65 and older live in some kind of "planned" elderly housing in our area. The vast majority of these persons moved into these buildings when the buildings were new, and the residents were healthy, active and quite independent.

Twenty years later, the picture has changed. The buildings and their residents are 20 years older. This increasingly frail resident population has been able to "age in place" and has been remarkably able to adapt and meet their own needs--to date. However, the mechanisms that are presently in place to assist them are being strained to the breaking point. While the housing managers are in a physical position to help coordinate the services that these persons need, they are often not in a good philosophical position to do so.

In 1988, we had the opportunity to have the services of the Gerontological Society of America's Fellowship Program in Applied Gerontology, in the person of Raymond M. Leinbach, to help us disentangle the issues, and to recommend some "next steps" for us in meeting the needs in our area. I am sending you a copy of his report, and hope that you will note that a collaborative effort--among housing providers and community-based service providers, and across funding sources (Title XX, Title III, United Way, etc.)--seems our best local solution. The two essential on-site services appear to be (1) congregate meals, and (2) some kind of case management.

I wish you every success in your work on this issue.

Yours truly,

Hal Freshley

Hal Freshley, Ph.D.
Senior Planner/Aging

AGING

A Study of
TWO CONGREGATE HOUSING PROGRAMS
in the Twin Cities

SEPTEMBER 1988

Gerontological Society of America
METROPOLITAN COUNCIL

A STUDY
OF
TWO CONGREGATE HOUSING PROGRAMS IN THE TWIN CITIES

BY

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Summer 1988

Prepared for

The Metropolitan Area Agency on Aging
of the
Metropolitan Council of the Twin Cities Area
Mears Park Centre Building
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St. Paul, MN 55101

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ACKNOWLEDGEMENTS

It is not possible for an "outsider" to complete a project such as this without substantial local support. This I have had in abundance. Assistance has been forthcoming from the sponsoring agency, those associated with the two congregate housing programs, and those who conducted our survey.

My most sincere thanks go to LaRhae Knatterud, director, and Hal Freshley, Senior Planner, of the Metropolitan Area Agency on Aging. They were instrumental in every phase of the project from its conceptualization through the printing of the final report. If the project is deemed successful, they deserve much of the credit. Other members of the AAA have also been generous with their time and that is appreciated. Florence Hauber was a helpful consultant for those ever present programming problems. Linda Dahle deserves special mention for her patience in typing this report.

To say that the project could not have preceeded without the support of the two congregate housing program directors is a decided understatement. Both Elaine Anderson of the Congregate Housing Services Program in St. Paul and Burton Deane of the Congregate Housing Program in Minneapolis warrant commendations for performance above and beyond what I had a right to expect. They were extremely generous with their time and were always very cooperative. Both went out of their way to grant access to program records and to encourage program participants to cooperate with our survey. The success of this project, no less than the success of the two congregate housing programs investigated, is due to the dedication and commitment of these directors. Another way in which the directors were helpful was to supply me with names of community individuals who were key information sources. At every turn I found cooperative community people willing to share their congregate housing experiences with me.

Finally, mention must be made of those who participated in the Pre-Admission Screening interviews that were conducted for this study. Todd Monson, the director, and the screeners from the Hennepin County PAS office also deserve a special thank you. The cooperation of the 76 congregate housing participants is also acknowledged. It is rather difficult to conduct a survey without respondents.

Ray Leinbach
10-1-88

ABSTRACT

The Metropolitan Council, which is the Twin Cities' Metropolitan Area Agency on Aging (MAAA), in cooperation with the Fellowship Program in Applied Gerontology of the Gerontological Society of America, sponsored this study in order to learn more about two congregate housing programs operating in the Twin Cities. Because of its concern for the growing proportion of residents in the area's high-rises who are over the age of 80, and its recognition that increasing numbers of these residents will require some services to allow them to "age in place," MAAA sought to determine if either or both of the congregate housing programs might serve as models for developing other similar housing-and-service arrangements.

This study was carried out during the summer of 1988 and took an in-depth look at these two programs. The conclusion reached is that the two programs both "work." That is, they each provide an effective array of services tied together by extensive case management. It is also concluded that the two programs are more alike than they are different. Similar services are offered, similar clients are served, the city's public housing agency is extensively involved in both programs, and many procedures are similar. The programs differ in that the program in St. Paul serves clients who are somewhat older and more disabled, requiring more services.

The investigator recommends that the MAAA give careful consideration to assuming a leadership role in the development of additional congregate housing programs based on the lessons learned from these two efforts.

EXECUTIVE SUMMARY

The Metropolitan Area Agency on Aging (MAAA) is one program of the Metropolitan Council of the Twin Cities Area. The MAAA receives its mandate as a planning agency from the general planning mandate of the Metropolitan Council and from the federal Older Americans Act. The Council is a creation of the Minnesota Legislature with broad planning responsibilities for Minneapolis and St. Paul and the surrounding seven counties. The Older Americans Act gives the MAAA broad responsibilities to develop on behalf of older persons a "comprehensive, coordinated system of services." This responsibility requires the MAAA to identify the unmet needs of older persons and to act to fill the service gaps which they perceive to exist. Because MAAA was aware of the unmet needs of those older persons who had difficulty maintaining independent living, yet were not dependent enough to warrant nursing home placement, and because it was aware of the two local congregate housing programs which offered some hope of helping to fill this unmet need, it sponsored this study in conjunction with the Gerontological Society of America (GSA). GSA was able, through its Fellowship Program in Applied Gerontology, to assist in the recruitment of an individual to study these two congregate housing programs.

The study's intent was to familiarize the MAAA with these two programs, one in Minneapolis called the Congregate Housing Program (CHP) and one in St. Paul called Congregate Housing Services Program (CHSP), so that it might have enough background to determine if it wanted to pursue the development of additional congregate housing programs.

This intent dictated a multi-dimensional approach to the investigation. A look at the services provided by each congregate housing program would not be enough to meet MAAA's needs. Likewise knowledge of staffing patterns, budgets, and client characteristics would not suffice by themselves. Accordingly, a broad view was taken and is reflected in sections one through nine of this report. These sections focus on: 1) program histories, 2) organizational structure, 3) physical facilities, 4) staffing, 5) budgets, 6) program intake, 7) program services, 8) characteristics of discharged clients, and 9) characteristics of current participants. Section ten presents a comparative summary of the two programs, and the eleventh section contains conclusions, implications and recommendations from the investigator.

Findings from the first nine sections include:

Program Histories -- The program sponsored by the Public Housing Authority of St. Paul (CHSP) was able to secure a grant from the U.S. Department of Housing and Urban Development of $80,000 per year for five years. In Minneapolis, a congregate housing program (CHP) was established with very little new money, but with the cooperation of both the city's public housing authority and the Hennepin County Department of Community Services. The presence of the HUD money in St. Paul gave them greater budget flexibility and the capacity to hire additional staff. On the other hand, the lack of "outside" funding makes CHP less vulnerable to a cessation of federal money for congregate housing programs.

Organizational Structure -- CHSP, in St. Paul, is run entirely by the city's public housing authority, while CHP is a joint venture of the Minneapolis Public Housing Authority and the Hennepin County Department of Community Services. Both programs are located in public high-rises, and serve a designated sub-group of residents in those high-rises. The program in St. Paul serves 46 persons among a resident population of approximately 400 in two high-rise buildings. The program in Minneapolis serves 52 persons among a population of approximately 275 persons in a two-building complex.

Physical Facilities -- Because both programs are located in public housing for the elderly and handicapped, their physical facilities are quite similar, including the similarity of participants' apartments.

Staffing -- Staffing is one arena where there is considerable program difference. Both have a director with overall administrative duties and responsibilities for the case management provided for their clients. However, the CHSP director has a full-time assistant who has assumed important administrative and case management duties. The CHP Director has no such help available. In addition, CHSP also serves as a vendor for housekeeping/personal care services, so it has a much larger payroll and greater staff supervision responsibilities. The primary duties of the CHP staff relate to the emergency response system and the programming of social and recreational activities for the congregate housing participants.

Budgets -- The budget for CHSP in St. Paul is many times the budget for CHP. This is because of the involvement of CHSP in the operation of and payments for the housekeeping/personal care services and the congregate meal program. If these amounts are subtracted from the CHSP budget, the CHP budget total would be closer, although the extra staff person who serves as a sort of "assistant director" would still make the CHSP budget higher. For the year ending June 30, 1988, CHSP's overall budget amounted to about $170,000. For a similar time period, CHP's budget amount would be about $52,000.

Program Intake -- An extensive intake process is utilized by both programs. Each does a thorough assessment of the potential client and uses a Professional Advisory Committee to assist in making the decisions regarding the appropriateness of each applicant. Criteria for acceptance into the two programs is very similar: the potential participant must have some difficulties with independent living, but must not be so disabled as to need care in a nursing home or similar facility.

Program Services -- The package of services available to clients of both programs is very similar. First, all are recipients of housing (namely a fully equipped apartment) through their respective public housing authority. Second, all clients receive extensive case management services to help them maintain asindependent a life as possible. Third, all participants have congregate meals available to them. CHSP clients can get meals twice a day, seven days a week. CHP clients can get a meal once a day seven days a week. Fourth, all participants can receive housekeeping, personal care, and home health care either directly through their program or through a community service agency. Fifth, all participants can take part in activities programs available in their buildings. CHP clients have the advantage of a half-time staff person who provides activities solely for them. Six, a variety of other services, such as transportation, counseling, and leisure activities are available from community agencies. Both programs provide assistance to their clients in utilizing outside resources.

Discharged Clients -- Data was collected from all congregate housing clients who were "discharged" since the beginning of each program through June 30, 1988. Analysis showed that the average stay for participants for both programs was about 16 months. An overwhelming majority of those discharged went to a "more restrictive" environment: nursing home, other institutional setting, a hospital, or death. One difference in the length of stay between the programs is that in St. Paul's CHSP program, about 20% of the intakes were discharged prior to completing three months in the program. On the other hand, all of the CHP clients remained in the program for at least three months.

Current Participants -- Utilizing a modified version of the Pre-Assessment Screening questionnaire used to determine if an older person needs nursing home care, 78 of the current program participants were interviewed in order to determine their functional abilities and learn what services they might need and at what cost. The two program populations are similar in that they a) are older, b) possess multiple disabilities relating to the performance of normal tasks of daily living, and c) need a variety of supportive services. The two groups differed in that the CHSP group is on the average about five years older, more functionally disabled, and in need of more services at a higher cost.

The investigator concludes that both programs work. Each is able to marshall a package of services which allow disabled older persons to avoid unnecessary and more costly institutionalization. Given that each program evolved in a unique context of existing resources and community circumstances, both have successfully brought these resources together to meet their residents' changing needs.

It is recommended that the Metropolitan Area Agency on Aging give careful consideration to assuming a leadership role in developing additional congregate housing services in the Twin Cities area based on the lessons learned from these two programs.

BACKGROUND OF PROJECT

Several years ago, the Metropolitan Area Agency on Aging completed a study of elderly housing needs and preferences and, at that time, identified the need for more effective packaging of housing and services to provide supportive environments for the growing population of frail and elderly. The use of the large supply of both public/subsidized and nonsubsidized planned housing that is available in the metropolitan area seemed appropriate. The question was *how* the services needed by residents should be organized and paid for.

As a consequence, the Area Agency on Aging has been interested in learning more about the two congregate housing models developed in Minneapolis and St. Paul, to determine the similarities and differences bewteen the two models, to identify the characteristics of residents served (and service available to them), and to identify what, if any, roles the Area Agency on Aging might play in expanding the availability of congregate housing in the metropolitan area.

The availability of a Geronotological Fellow to complete an evaluation of the two congregate housing models provided a unique opportunity for us to gather data on the two models, describe, in some detail, the organization, provision and funding of those two models, and develop recommendations for our role in further expanding the availability of congregate housing in those areas where need exists.

We look forward to using this report as the basis for additional technical assistance to housing sponsors and service providers and as the basis for better direction of Title III funds into the support for congregate housing in the area.

LaRhae Knatterud
Metropolitan Area Agency on Aging Director

INTRODUCTION TO REPORT

Given the comprehensive interest of the Metropolitan Area Agency on Aging in the two congregate housing programs operating in the Twin Cities, it was necessary to take a multi-dimensional approach to this investigation. A look at the respective budgets would not be enough to meet the agency's needs. Likewise knowledge of the services provided or the characteristics of the participants or the organizational structure would not suffice by themselves. Accordingly, a broader view was taken and is reflected in the sections of this report. First, there is a brief history of each program. This will include a look at the process leading up to the establishment of each, plus developments after the programs were initiated. Second, the organizational structure will be discussed. One of the interesting differences between the programs lies in their organizational structure. The physical facilities will be the focus of the third section. Both the program's facilities and ~~the~~ participants apartments will be addressed. Fourth, the staffing of each will be explored. This will include staff formally included in the respective budgets as well as staff resources available from outside the programs. Fifth, the budgets will be reviewed. For a number of reasons, it is difficult to accurately depict the respective budgets and make program comparisons. Sixth, the all-important intake processes will be presented. The similarities between the program's processes will be evident. Next, in the seventh column, the services available to the congregate housing clients will be seen. While the service package available for the respective program participants is quite similar, there are some noteable differences. The eighth section deals with the characteristics of those who have "terminated" or been "discharged" from the programs. Program comparisons are made regarding how long clients remained in the program and their reasons for leaving. The ninth section will contain comparative data on the current participants. A Pre-Admission Screening instrument (used to screen nursing home applicants) was utilized as an interview schedule for the current congregate housing clients. These data provide another basis for program comparisons. In the tenth section there will be a comparative summary of the two programs based on the material in the preceding ten sections. The eleventh, and final, section contains thoughts from the investigator regarding implications for the Area Agency on Aging for future actions.

SECTION ONE -- PROGRAM HISTORIES

Both programs were significantly influenced by the involvement of the Public Housing Authorities (PHAs) in their respective cities. In one instance, the PHA became the program sponsor and in the other it became a co-sponsor. Therefore, we find the concerns of these agencies were crucial foci for program development.

As is the case with most public housing authorities across the country, the two in the Twin Cities were strongly influenced by the size and age of their older resident population. Minneapolis and St. Paul have an abundance of public housing for the elderly and handicapped--about 7,800 rental units. Because many of the projects were built 15 or 20 years ago and because many of the older tenants remain in public housing once there, both PHAs were faced with the "aging-in-place" phenomenon. That is, residents who moved into the high-rises at age 70 and remained there were now in their 80s or even 90s. While age is far from an adequate predictor of fraility by itself, it is safe to assume that as the older tenant population aged, they tended to become less functionally independent. For the PHAs, this meant an increasing number of residents who either needed to be relocated or needed to be given assistance in order to maintain themselves in the high-rises. This caused the PHAs to consider whether they wanted to a) remain primarily a housing provider and expect tenants to fit the available housing resource, or b) attempt to expand into the realm of social service provision in order to allow present residents to remain in public housing. The former position is referred to as the "constant model" because the service--housing--remains constant and the expectation is that the tenants will adjust if an adjustment is needed.

The latter is referred to as the "accommodating model" because the housing sponsor becomes involved in adjusting its services to meet the changing needs of its constituency.[1] The accomodating model does not necessarily mean that a PHA must become a "social service agency," but it does mean important chnages within the organization.

To imply that this concern--aging public housing residents--rested solely with the PHAs would, of course, be erroneous. Other agencies shared these concerns for they too were impacted by this aging-in-place. Federal, state, and local governments were concerned over the increased financial commitments needed to maintain the older population. Local direct service agencies were increasingly serving high-rise residents; this was particularly true of the county social service departments. These departments were becoming more involved with the high-rise residents because many of them were lower income and "income eligible" for public services. The Metropolitan Area Agency on Aging was naturally concerned because of its responsibilities to monitor and plan for the service needs of older Twin Citians.

The passage of the Congregate Housing Services Act in 1978 as Title IV of the Housing and Community Development Amendments and the appropriation of $10 million to HUD for 60 congregate housing service programs provided the impetus for many public housing authorities to consider movement toward the accomodating model. This enactment and its concomitant regulations were to have significant influences on the development of the two congregate housing programs discussed in this report.

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[1] Lawton, M.P., Greenbaum, M., & Liebowitz, B. (1980). The lifespan of housing environments for the aging. The Gerontologist, 20 (1), 56-64.

CONGREGATE HOUSING SERVICES PROGRAM (CHSP) - RAVOUX/VALLEY

On March 6, 1980, the U.S. Department of Housing and Urban Development published in the Federal Register (Vol. 45, No. 46) a notice of fund availability for the Congregate Housing Services Program (CHSP). Interested applicants had until March 21, 1980 to submit a "letter of interest" indicating a desire to be a sponsor for one of the pilot projects. The Public Housing Authority of the City of St. Paul submitted such a letter. They were selected to proceed with a formal application, which they did on June 23, 1980. On October 10, 1980, they received word from HUD that they had been selected to "enter into negotiations for a grant award." This required the submission of a Statement of Work and final Program Budget. These were submitted in November, 1980. Later that year, the PHA of St. Paul learned of final acceptance.

Because of the HUD funding, the program naturally developed along the lines of the specified guidelines. It is instructive at this point to list some of these:

- Each applicant shall provide a minimum of two meals per day, seven days a week for program participants, and shall develop a sliding fee scale based upon ability to pay under which program participants may pay part or all the cost of meals and other services.
- Each applicant may request funds for the provision of housekeeping and/or personal services, and other supportive services as necessary to maintain the participant's independence.

- HUD funding for CHSP grants is limited to a maximum of $400,000 to be expended in approximately equal annual sums over the 5-year period of the grant.

- Projects of the elderly generally will be expected to limit participation in the CHSP to no more than 20 percent of the total resident population.

- Each grantee shall appoint a Professional Assessment Committee (PAC) made up of at least one medical professional and two others qualified to assess functional ability of elderly and non-elderly handicapped and temporarily disabled residents. The PAC will screen all interested project residents for program eligibility/admissions/termination to the CHSP, and make appropriate recommendations to project management for action.

- HUD will conduct an in-depth evaluation to determine: the extent to which coordination is achieved between other Federal programs and HUD; the extent to which CHSP avoids or creates a duplication of existing programs; and the extent to which the program is successful in preventing unnecessary or premature institutionalization of elderly and non-elderly handicapped persons. (March 6, 1980 Federal Register, pages 14822-14823.)

Final word of the impending receipt of funds in the spring of 1982 prompted the Board of Commissioners of the PHA to approve the director's position for the CHSP. The individual was hired in April, 1982, and the first participants entered the program on October 4, 1982. This six-month "start-up" period allowed time for final arrangements for services and for client recruitment. During this period as apartments became vacant, they were held for CHSP. By October, there were 20 units available. In October, 19 participants entered the program (some of whom already lived in the building), by the end of 1982, 31 had entered, and by March 31, 1983, CHSP had reached its maximum of 46 participants.

One of the reasons that the Ravoux high-rise was chosen was that it had a higher vacancy rate than some of the other "elderly" high-rises. It was also chosen because of its size. This was an issue because HUD specified that only 20% of the units in a building could be utilized for CHSP. Therefore, in order to obtain a higher number of program slots, a larger building was chosen. Ravoux was well located for public transportation, already had a large number of older persons who were considered frail, and was a short distance from St. Paul-Ramsey Medical Center.

In May, 1980, the Resident's Council at Ravoux gave its approval for PHA to submit its grant application with Ravoux as its site. In the Spring of 1982, however, the Council's president attended a meeting of the Board of Commissioners asking to withdraw the previously granted approval. The president was told that because the grant had been approved and final plans were underway, the program would continue as planned.

On September 1, 1987, one half of the CHSP slots were transferred to Valley high-rise. After almost five years of the program, the PHA had learned that few residents of other high-rises would move to Ravoux even if the need appeared great. There was already a congregate dining site at Valley and a number of its residents were in need of more services.

(In subsequent discussion the St. Paul congregate housing program will be referred to as "CHSP" and will include both Ravoux and Valley high-rises unless otherwise stated.)

CONGREGATE HOUSING PROGRAM (CHP) - LYNDALE MANOR

The concerns described above regarding aging-in-place as well as vacancy rates in elderly high-rises applied equally to the Minneapolis Public Housing Authority (MPHA) and to related community agencies. On the 19th of March, 1980, the executive director of MPHA sent a letter of interest to HUD expressing the desire of MPHA to compete for funding for a CHSP. MPHA was not invited to present a formal application, so was not priviledged to have outside financial resources available.

In late 1981, the MPHA and the Hennepin County Department of Community Services (HCDCS) jointly formed the Congregate Housing Facility Planning Committee. It was made up of representatives from a variety of community agencies. The first meeting took place in early 1982. The Committee's purpose was to develop a proposal for a congregate housing program in Minneapolis. Primary leadership came from MPHA and HCDCS's Services to Seniors unit.

The Committee presented its final report in September, 1982. This report covered topics similar to the grant applications submitted to HUD for CHSP funds. With the federal CHSP guidelines in hand, knowledge of the St. Paul program, and with common concerns about inappropriate institutionalization, aging-in-place, and high vacancy rates, it is not surprising that the substance of the two programs is very similar.

Lyndale Manor was chosen for the Minneapolis program (they call their's Congregate Housing Program) because of its location close to shopping and public transportation, available space for meals, and its vacancy rate. During the nine months of 1982 while the Committee was preparing its proposal, the vacancy rate at Lyndale Manor averaged a little over 5%. By the time the program director was hired, September, 1983, the vacancy rate stood at 14.6%.

Because there was no new funding available, the Committee attempted to develop a program which could operate within the framework of existing resources. On page 10 of their report they state:

> It was the intent of the Committee which developed this proposal to recommend, to the extent feasible, a program which would not require additional resources beyond those currently allocated for services to disabled adults. This proposal will, however, require a reallocation of existing resources.

They proposed that MPHA provide facilities and that HCDCS provide staffing. The director was to be a senior social worker from the HCDCS's Services to Seniors unit. The two agencies accepted these recommendations and on September 6, 1983 a senior social worker began work as the Congregate Housing Program (CHP) director. Lacking a six-month developmental period, this program was slower in recruiting particpants. The first three entered in November of 1983 with three more entering in December. By September of 1984 there were 14 participants and by July 1, 1988 the enrollment was 52. The maximum CHP enrollment of 60 has not been reached.

(Hereafter the Minneapolis program will be referred to as CHP.)

SECTION TWO -- ORGANIZATIONAL STRUCTURE

Congregate Housing Service Program (CHSP)

Because CHSP in St. Paul is a component of the city's PHA, the organizational structure is uncomplicated. The director of CHSP reports to the PHA's Director of Resident Services. This department is a large unit with such responsibilities as public housing intake, human services to residents, Section 8 subsidies, and management services for all types of residential facilities. The director of this department reports to the agency's executive director. The executive director reports to the PHA Board of Commissioners, who are appointed by the mayor of St. Paul.

Congregate Housing Program (CHP)

The organizational structure for the program at Lyndale Manor is a bit more complex. The MPHA provides space and maintenance services. It is responsible for intake of CHP participants into the building. (They must first be acceptable as tenants before they can be CHP participants.) MPHA is also responsible for ongoing monitoring of residents to insure they are able to meet cleanliness and safety standards for occupancy. They forego rent on two apartments and provide another room which serves as the director's office. One apartment is provided to the resident Program Assistant and one apartment is utilized as an activity's room and the site for weekend meals.

The HCDCS supplies, among other things, a senior social worker who serves as CHP's director. The chain of command goes from the director to his supervisor in HCDCS's Services to Seniors unit, then proceeds up the organization to the Director of Community Services Department on to the Hennepin County Board of Commissioners.

It is interesting to note that while there were exchanges of formal letters as the program was starting, there is no formal document which outlines the continuing relationship between these two public bodies regarding CHP.

SECTION THREE -- PHYSICAL FACILITIES

Because both CHSP and CHP operate in public high-rises for the elderly, the physical facilities are very similar.

Congregate Housing Services Program

Since September, 1987, CHSP has operated in two buildings. Ravoux is an 8-story high-rise located at 280 Ravoux at the corner of Marion Street. It is bounded on the one side by I-94, on another by a large Sears store and adjacent parking lot, and on the other two sides by single-family and small apartment dwellings. Ravoux consists of 220 units, all of which are one-bedroom. The typical apartment ranges in size from about 400 to 450 square feet, contain a complete kitchen with range and refrigerator, and a complete bathroom with a tub.

Valley is an 11-story high-rise located at 261 E. University Avenue across the street from St. Paul-Ramsey Medical Center. Behind Valley is an area occupied by PHA units for families. There are 98 one-bedroom units and 97 efficiencies in Valley. All units contain a complete kitchen with range and refrigerator and a complete bathroom with tub. The one-bedroom apartment has almost 500 square feet and the efficiency has about 300 square feet.

Both buildings have a kitchen sufficient to serve congregate meals and a dining area big enough to accommodate a congregate dining program. This dining area doubles as a common area for other activities.

Congregate Housing Program

Lyndale Manor is a five-story, two building complex located at 600 - 18th Avenue North Street. It is bounded on one side by a shopping area, on two other sides by single family dwellings, and on the other by a large Target store. There are 288 units of which 174 are one-bedroom and 114 are efficiencies. All units contain a complete kitchen with range and refrigerator, and a complete bathroom with a shower. (No units have bathtubs, although there are tubs on two floors in each of the buildings.) The typical one-bedroom unit consists of about 470 square feet and the typical efficiency has about 350 square feet. At Lyndale Manor a studio bed is furnished with the efficiency units. The building has a kitchen and dining area large enough to accomodate a congregate meal program. The dining area also serves as an activities room for the high-rise residents.

Some Common Characteristics

All three buildings have some common aspects. None of the apartments is air conditioned, although the tenant is allowed to install his or her own unit providing it meets established building requirements. All buildings have coin-operated laundries. The utilities are paid for by the PHA. Tenants are responsible for the cleanliness of their own units and are subject to periodic inspections. All apartments have their own thermostats.

SECTION FOUR -- STAFFING

For purposes of this report, program staff will be considered only if they are officially funded through the program's budget or formally assigned to the program by an outside resource. Outside service agencies, such as a visiting nurse association, a transportation service, or mental health service will not be considered even though they may regularly serve the needs of some program participants.

Congregate Housing Special Program

The St. Paul PHA organizational chart lists six positions for CHSP. In addition, CHSP has the services of three Senior Aides, one of whom is assigned clerical duties for the program. Also from time to time CHSP participants have been assigned Senior Companions, but these are not considered part of the regular staff herein.

The CHSP director is a full-time employee who has overall responsibility to "manage, coordinate, monitor and evaluate the various components and services of the CHSP, and supervise the CHSP staff." At the beginning of the program the director had to perform all of the intake and case management. More recently a CHSP Program Services Assistant III has been hired and has relieved the director of some intake and case management responsibilities. In addition, this Services Assistant III has assumed CHSP meal responsibilities and is the liaison between the program and the two high-rise resident councils.

There are four other Program Services Assistants (levels I and II) who maintain the most frequent direct contact with participants* by a) performing housekeeping services, b) doing some non-medical personal care, and c) providing assistance at meal time.** Three of these individuals are employed 30 hours a week and one is employed 25 hours a week. While these four positions are funded in the CHSP budget by HUD, CHSP receives reimbursement for some of their services because it is a vendor with Ramsey County Community Human Services Department (RCCHS): PHA has a purchase of service agreement with RCCHS whereby CHSP is reimbursed for housekeeping and personal care services provided to income-eligible CHSP participants.

Congregate Housing Program

At Lyndale Manor the CHP director, an HCDCS employee, also has broad overall responsibilities. The director supervises other staff, does all the intake, case management, and coordination/public relations activities. There is no one employed to help the CHP director in carrying out these duties. Secretarial support comes from the Northside Office of Services to Seniors (HCDCS), which is just a few blocks away.

There is one Program Assistant whose primary responsibility is the operation of the emergency response system for CHP clients. This person is provided a rent-free apartment at Lyndale Manor and a small monthly stipend.

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* Services are discussed in greater detail in Section Seven.

** CHSP supplies about 84 staff hours a week to the program which operates the congregate dining site. At each site, a CHSP staff person works two hours Monday through Friday and four hours for the other eight congregate meals-- (2x5 + 4x8) x 2 = 84.

He is to be on duty from 4:30 p.m. to 8:00 a.m. Monday through Friday and from 4:30 p.m. on Friday until 8:00 a.m. on Monday. There are 106.5 hours of relief provided for during each month. In addition, this person is to get to know each participant and perform some related duties.

Relief for the Program Assistant comes from the seven Program Aides who work part-time and are paid by HCDCS. While their primary responsibility is to provide relief for the emergency response system, they perform related duties such as helping with the provision of the weekend meals.

CHP has the services of two Senior Aides provided through East Side Neighborhood Servcies, Inc., a local private, not-for-profit agency. These persons work up to 20 hours per week and are assigned only to the CHP. One performs a variety of ancillary roles under the supervision of the CHP director, the other serves as the director of activities for CHP participants. All of the Program Aides and Senior Aides are residents of Lyndale Manor.

Finally, there are two Senior Companions assigned to CHP participants through the Senior Companion Program operated by the Minnesota Association of Retarded Citizens. Those Senior Companions differ from those utilized in CHSP because they are assigned only to work with CHP participants for their entire 20 hours of work a week.

Staffing Comparisons

A few differences in staffing stand out. The most critical is that CHSP has a full-time employee who serves as an assistant to the director and is capable of assuming important administrative and program duties. There is no such help available to the director of CHP in Minneapolis. Two, because CHSP employs housekeeping/personal care personnel, it can exercise greater control over these services. At Lyndale Manor CHP participants receive these services from outside vendors and those staff report to persons outside the program. Three, CHP has a 20-hour per week person assigned to provide activities for its CHP participants. In St. Paul, CHSP participants take part in activities available to all high-rise residents, but there is no staff person who regularly provides activities only for them. Fourth, CHP employs individuals to staff its emergency response system. Emergency services available to CHSP clients are the same services available to any PHA high-rise resident.

Resident Profile

- **Predominately female.**
- **Widowed, divorced, single.**
- **Average age: early 80's.**
- **Low income population in publicly sponsored programs; moderate/upper income in private programs.**
- **Residents come from the area surrounding the congregate facility.**
- **Residents view the environment as a residential option, not a level of care.**
- **Motivations for choosing a congregate housing/services facility: affordable, safe environment, social opportunities, continued independence, accessible services.**

Surveys indicate that as the proportion of older residents in age segregated housing/services projects increases, the proportion of females increases, which parallels national female/male ratios.

The ratio of females to males was 80/20 in Malozsemoff's (1978) national survey of congregate programs, and 48 per cent of the residents were 80 years of age and over. Mor (1986) quotes several descriptive survey sources which indicate a 70/30 F/M ratio, with 30% of residents over 80. Mor's (1980) own survey of residential care programs found 67 per cent female and 42 per cent over 75. Massachusetts' state-sponsored congregate program ratio of F/M is 61-39. However, 44 per cent of the men were 65 to 74 years of age, while 43 per cent of women were 75-84 years of age (Guidelines, 1984). Surveys and discussions with congregate facility managers indicate that the average resident age has increased over the years, reflecting several trends: the aging-in of long time residents due to increased longevity, consumers' availability of in-home services extending independent living in private homes/apartments and delaying relocation to supportive-service congregate environments, congregate applicants entering congregate facilities at later ages, and the trend of congregate facilities for providing a more intensive level of care and thereby allowing residents to remain in the congregate project longer. The proportion of male residents is also increasing, reflecting a greater acceptance among emerging older cohorts of congregate living as an alternative living environment.

Lawton, *et al.* (1980) suggests three factors that account for the environmental image of a housing/services project: (1) administrative policies which impose strict behavioral and health admittance standards; (b) administrative policies which strictly adhere to discharge procedures; and (c) self-screening by potential tenants who base their decision to enter a congregate facility upon whether the project's current character matches their needs and preferences.

Ninety four per cent of the residents in Malozemoff's national survey had annual incomes below $12,000, with the majority having incomes of $6,000 or less. The Mor survey of state-sponsored programs did not document income levels, but one fourth had 100 per cent SSI recipients and half had 26-99 per cent SSI recipients as residents. Most state-sponsored programs target low/very low income elderly since the purpose of these programs is to provide a less costly alternative to those who may ultimately become eligible for more costly higher levels of subsidized care.

In the general community, 28 per cent of men aged 75+ and 76 per cent of women aged 75+ are single (SB Statistical Bulletin, 1984). Ninety four per cent of the residents in Mor's survey were single, widowed, divorced, and 97 per cent of Massachusetts' congregate residents were single or widowed. Ninety per cent of the men in Mor's sample and 95 per cent of the men in the Massachusetts study were single. Elderly married couples provide informal care for each other (Tell & Wallack, 1984), live in their own homes, have higher income, suffer less insecurity and loneliness, and maintain an independent style of living longer than single older adults.

Congregate facilities report that the great majority of their residents come from the surrounding area. The Massachusetts study shows typical results: 77 per cent of residents came from the same community as the facility or a community adjacent to the facility. Only 3 per cent came from outside Massachusetts, most of these coming in order to live near a family member. Eighty five per cent of Massachusetts' congregate residents have a family member within a 20-mile radius of the facility. Referrals are made by local service providers, family members, or are self-referred.

Potential residents do not view a congregate housing/services facility as a housing option that is different from conventional housing (Malozemoff, *et al.* 1978; Johnson, 1985). Relocation to a congregate facility is not seen as the final move and, therefore, is not as traumatic as a move to a nursing home.

People move to congregate housing for various reasons. The affordable cost is important to widowed and single people, urban dwellers, renters, low income elderly, and Blacks (more have low income). The security inherent in a safe building, being part of a group, and having the presence of program staff is important to single women, frail elderly, urban rooming house residents, and low income persons and urbanites moving from deteriorating neighborhoods. For displaced urbanites who have lost their homes/apartments in rehabilitation projects, or suburban and rural homeowners who can no longer afford the repair, upkeep and taxes, a congregate facility may be the only viable option, and simply represents shelter.

The convenience of services is attractive to middle class persons and over-housed suburbanites who wish to escape the costs and burdens of home ownership. The availability of services is important to widowed men who are unused to caring for themselves and to the more affluent who view services as a convenience, not a necessity. In Malozemoff's (1978) survey of 27 facilities (including six Continuing Care Retirement Communties), 37 per cent of residents were married. This percentage is much lower in publicly funded congregate facilities. When married couples move into a congregate facility, they cite health problems, difficulties in keeping up their homes, and climate as reasons for relocation.

Older, isolated, frail, single or widowed persons, particularly women, cite loneliness as the reason for moving to a congregate housing/services facility.

In the Malozemoff survey, 22 per cent listed "hard to keep up home/apt" as their *primary* reason for moving from their previous residence. Seventeen per cent moved primarily because they were "concerned about becoming a burden/wanted to maintain independence." Eleven per cent could not afford to stay in their previous homes. "Health reasons" was ranked by only nine per cent as their *primary* reason for moving. As to choosing a congregate facility instead of another alternative, the first reason for 16 per cent was that the facility was "closer to family and friends." Nine per cent said the facility was "in their home town." Eight per cent listed, as their first reason for choosing congregate, "independence and flexibility" in life style; 7 per cent picked "food and other services;" and 6 per cent cited "the medical program" as their first reason.

In general, younger residents were not seeking the age specialized design of congregate facilities (Sherman, 1971; Malozemoff, 1978), nor was the availability of support services or meals a strong determinant for their choice. For younger residents, the decision to move to congregate was based on the location of the facility and a preference to remain independent in the community. For waiting list applicants, "the medical program" ranked 14 out of 15 as an attractive reason to move to a congregate housing/services project, and "food and other services" ranked tenth. As the age of potential residents increased, declining health status increased as a reason for moving into a congregate facility and an on-site health program increased as an attraction, but still was not the prime attraction in choosing a congregate facility.

Reasons For Choosing Congregate Housing
Residents and Applicants

	RESIDENTS		APPLICANTS	
REASONS	1st Reason %	All Reasons* %	1st Reason %	All Reasons* %
Special design features for maneuverability	2.0	18.0	2.4	16.9
Closer to stores, transportation	7.0	27.0	10.6	39.7
More people to be friends	5.0	27.0	8.2	34.9
In safe neighborhood	2.0	12.0	0	19.3
Alarm system for emergency	2.0	13.0	0	9.6
Physically better/more attractive	6.0	16.0	2.4	12.1
Closer to family & friends	16.0	33.0	20.2	49.4
Food and other services	7.0	35.0	2.4	28.9
Variety of activities	1.0	10.0	1.2	19.3
Medical programs	6.0	22.2	1.2	14.5
In home town	9.0	28.0	13.0	38.5
Reasonable cost	7.0	12.0	7.0	10.8
Management friendly	3.0	8.0	0	8.4
Only place to go	5.0	7.0	1.2	4.8
Independence/flexibility	8.0	12.0	13.2	19.3
Forced by family	2.0	2.0	0	0
Church-sponsored	4.0	7.0	5.2	9.2
Climate	4.0	7.0	5.2	9.2
Other	4.0	7.0	5.2	9.2
TOTAL	100.0% N = 469		100.0% N = 83	

*Duplicated count: This column total is greater than 100%

Housing for the Elderly: Evaluation of the Effectiveness of Congregate Residences (Malozemoff, Anderson, and Rosenbaum, 1978)

Reasons For Moving From Previous/Present Residence
Residents and Applicants

	RESIDENTS		APPLICANTS	
	1st Reason %	All Reasons* %	1st Reason %	All Reasons* %
Distance from family/ friends	5.0	8.0	11.1	8.0
Unsafe in neighborhood	6.0	13.0	2.3	13.0
Concerned about emergency	7.0	24.0	11.7	24.0
Couldn't afford to stay there	11.0	19.0	9.4	19.0
Access to community difficult	2.0	13.0	4.7	13.0
Hard to keep up home/apartment	22.0	42.0	12.9	42.0
Family encouraged move	7.0	23.0	3.5	23.0
Health reasons/Doctor's orders	9.0	14.0	4.7	14.0
Independence/concern about being a burden	17.0	21.0	35.2	21.0
Home torn down	4.0	5.0	0.0	5.0
Lonely	5.0	7.0	1.1	7.0
Climate	1.0	2.0	1.1	2.0
Other	4.0	8.0	2.3	8.0
TOTAL	100.0% N = 469		100.0% N = 85	

*Duplicated count: These column totals are greater than 100%

Housing for the Elderly: Evaluation of the Effectiveness of Congregate Residences (Malozemoff, Anderson, and Rosenbaum, 1978)

SECTION FIVE -- BUDGETS

Several factors operate to make budget comparisons between the two programs difficult. One, the total amount of money which is controlled by each; two, the fact that different line-items appear in each; three, the exclusion of substantial "in-kind" resources utilized in both; and four, the fact that different services are provided through the respective budgets.

Congregate Housing Special Program

The financial statements submitted by CHSP to HUD show that from program inception (April, 1982) through June 30, 1988, it had federal expenditures which totalled $468,532.68, or a mean average annual expenditure of about $75,000. For the period July 1, 1987 through June 30, 1988, CHSP had federal expenditures totaling $97,000.

Significant in-kind resources are not included in these amounts. For example, PHA provides supervision for the CHSP director, accounting services, and an apartment at Ravoux which is used as the CHSP office, plus a smaller room used as the Valley office. Community in-kind comes from volunteers, PAC members, and various service agencies.

Also not included in the federal expenditures are substantial amounts of program income received from or on behalf of participants. The latter comes in the form of vendor payments by the Ramsey County Community Human Services Department for the provision of housekeeping/personal care services by CHSP staff. The former comes from participants for their meals. When program income is added to the amount available from HUD, CHSP had total cash income of about $170,000 for the four quarters ending June 30, 1988.

Much of the program income from meals is obligated to the Senior Nutrition Program operated by Ramsey Action Program (RAP). As per the CHSP-RAP agreement, CHSP pays a set amount for each of the 14 meals RAP provides for CHSP clients.

Congregate Housing Program

Determining expenditures for the Minneapolis program is both easier and harder. It is easier because its budget does not include items for meals or housekeeping/personal care, and harder because there are two sponsors.

There is no budget available from MPHA for its in-kind contributions to CHP. While its contributions are significant (two apartments, an office, plus maintenance, upkeep and utilities), it does not maintain a separate account for CHP.

The CHP budget from HCDCS includes amounts for the director, a monthly $300 stipend for the live-in Program Assistant, about $220 a month for Program Aides, and a small amount for materials and supplies ($43/month). On an annual basis this amounts to about $52,300. Approximately $8,000 of that was money newly allocated for CHP; the director is a senior social worker who was transferred to CHP and did not "cost" HCDCS anything additional.

There are some in-kind contributions which are essential to the program. Estimates from MPHA are that rent foregone on two apartments plus maintenance, upkeep and utilities amounts to about $11,000. Hennepin County provides supervision for the CHP director, telephone service, a beeper for the director, secretarial services, and a small amount for the director's mileage. (It was not possible to obtain cost estimates for this list.)

Budget Comparisons

Comparing the $170,000 available to CHSP for the year ending June 30, 1988 with the 1988 budget of $52,300 from Hennepin County for CHP gives the impression of a sizeable difference in available resources. Closer inspection belies this initial impression. The primary reason for this $119,105 differential is the inclusion of meal and housekeeping/personal care services within the CHSP budget. For CHP these services are provided to participants (see Section Seven), but they are provided outside the CHP budget and with less effort on the part of CHP staff.

Trying to make comparisons between the two budgets is difficult at best. If the budgets could be somehow equalized, such as by extracting the meal and housekeeping/personal care services from the CHSP budget, the major differences would be the additional staff person available to CHSP to assist the director and the $8,000 available to CHP from HCDSC for its emergency response system and some program incidentals.

SECTION SIX -- INTAKE PROCESS

The area of greatest similarity between the two programs is in the way they admit participants. One reason for this is their common knowledge of the mandates for the federal Congregate Housing Services Program. Another is that CHP was able to benefit from knowing how CHSP had established its intake process in St. Paul. A third reason is that both programs operate in public housing facilities.

Because intake is so alike, that basic process will be outlined here rather than datailing each separately. A few exceptions will be noted.

An applicant begins by filling an application with 1) the public housing authority for admission to the respective high-rise, and 2) with the congregate housing program. Next, staff of the congregate housing program conduct a functional assessment interview, review a physician's statement, and verify applicant's financial status. If the applicant is eligible for public housing, the staff share the application material and personal recommendation with the Professional Assessment Committee (PAC). The applicant is then notified in writing of the decision.

In the event of a denial, the appeal process is explained. An individual can be denied admission if she or he is too frail or not physically or mentally disabled enough to warrant services at the level proivded by congregate housing programs. To date, neither program has had an applicant follow through with the appeal process.

All accepted applicants have an Initial Service Plan developed for them.

Public housing eligibility is virtually identical in both cities. The maximum annual income for a single individual is $22,700. Residents must be able to maintain their own apartment either by themselves or with assistance from others. Periodic inspections are made of the rooms to check safety and sanitary conditions. The rental fee is 30% of Adjusted Monthly Income.

CHSP has not conducted on-going intake for some years because it has been at maximum enrollment. When a vacancy occurs or is pending, it processes applications. CHP has not reached its maximum, and therefore has on-going intake as potential clients are identified.

One other dissimilarity is that as of early 1988, CHP had added an in-home health assessment to its process. This assessment is conducted by an RN from the visiting nurse association at no cost to the program.

Both PACs have members who are nurses and representatives from the PHA. PACs are also utilized in any situation where a client might have to be demitted.

SECTION SEVEN -- SERVICES TO PARTICIPANTS

This section is organized by service rather than by program as is done in the other sections. This is so that comparisons between programs can be discussed immediately.

Housing - Each program rely on public housing as one of its basic services. Program participants receive the same services as non-congregate housing residents in their respective buildings. In all cases the residents must meet income eligibility requirements and pay 30% of their Adjusted Monthly Income as rent. Both programs originally planned to segregate congregate housing clients, but a change was made before each began. Congregate housing participants are now integrated throughout their buildings, although some consideration is given to closeness to the elevators, because these residents tend to be more disabled.

Case Management - Both programs provide case management services to all participants. This service actually begins prior to admission when each applicant has an Initial Service Plan developed. Periodically formal reviews of each applicant are carried out in order to maintain an appropriate service package. On an informal, and much more frequent basis, program staff monitor participant status and might intervene any time the case management function needs to be invoked. This could happen if an individual suffers a decline in functional ability or if there is an improvement. Both programs utilize their PACs to assist in the on-going monitoring of participant service needs.

Case management (in other settings known as "service management," "case coordination," "resource coordination," or "casework") is undoubtedly the service least likely to be understood by the congregate housing participant (while at the same time being the most appreciated by the client's "significant others"). It is the one service which most clearly separates congregate housing participants from their peers in the high-rises. A lack of appreciation of this service may account for the dearth of interest in both CHSP and CHP on the part of the older person living in other high-rises. As one Minneapolis housing official speculated, "High-rise older persons do not see any reason to leave their current apartments for one in another building. They believe they can have the same services in their own high-rise." Indeed, any public housing tenant might get a) home-delivered meals if a congregate meal site is not readily available, b) housekeeping services through the county social services department or through the Alternative Care Grant program, c) receive visits from a visiting nurse program (either home health aides or registered nurses), d) become a client of a community mental health agency, e) attend a senior citizens center for socialization and recreational activities, f) utilize special transportation services, and g) call upon 911 for emergency assistance. If this is the perception and if there is no appreciation of the value of case management, the logical conclusion would be to remain in one's present building.

Meals - All congregate housing participants have meals available to them. However, the specifics of the meal services are quite different for the two programs.

Because of its federal mandates, CHSP, from the outset, provided two meals a day, seven days a week in Ravoux high-rise. (Fortunately for CHSP, RAP decided to open a congregate housing dining site at Ravoux as the program was being set up and was operating another site at Valley when CHSP moved some of its program there.) There is a larger meal served at noon, with a smaller "lunch" provided in the evening. On Saturday the participants are given a "bag lunch" at noon to take to their rooms for that evening's meal. All meals meet the standards for meals established by Title III-C1 of the Older Americans Act. HUD mandated that CHSPs "develop a sliding fee scale based upon ability to pay under which program participants may pay part or all of the cost of meals and other services." Accordingly, CHSP participants are charged for their meals at the same time they are billed for their rent. CHSP in turn pays RAP a fixed donation for each meal served: $1.25 for each meal except Sunday noon, which is $1.50. In addition, CHSP is obligated to supply staff at each meal--described above in Section Four.

Since 1987, HUD no longer requires participants to take two meals a day, seven days a week. Currently a participant can petition to waive the requirement for one of the daily meals. Most CHSP participants continue to receive two meals a day every day. Some are permitted to receive the meal in their rooms, but on a temporary basis only--every effort is made to see that the meal is eaten in the congregate setting.

In Minneapolis, CHP participants have available one meal a day, seven days a week--all of them at noon. Monday through Friday the meals are provided by Volunteers of America, Inc. at Lyndale Manor as an Older Americans Act Title III-C1 site. Because of negotiations carried out by its co-sponsors, CHP was also fortunate to have a congregate dining site open in its building as the program began. There is no billing for the meals. For the Monday through Friday meals, participants voluntarily donate what they think they can afford, as per the Older Americans Act.

No CHP staff time is provided to assist with these meals. On the weekends, Meals at Home supplies meals. There is a recommended donation for these meals ($2.20 per meal), but lower amounts are accepted. Participants sign up for the weekend meals ahead of time. CHP staff must go off-site to pick up the meals and then serve them in the apartment at Lyndale reserved for use by CHP.

Less than half of CHP's participants regularly take part in the weekday noon meal program. In early July, 1988, the site manager for the congregate dining program indicated that 21 or 22 CHP clients took meals regularly, with four persons receiving their meals in their rooms. (The CHP director confirmed these figures.) On a typical weekend 10 CHP clients get one meal a day.

Some of the major differences between programs include 1) the percentage of participants who are provided meals, 2) how often the meals are available, 3) method of "payment," and 4) the amount of programs staff time devoted to meal service.

Housekeeping/Personal Care - After housing, case management and meals, this service comes next as far as frequency of participant use. The two programs differ in the provision of this service, however. For the present discussion, included under this heading are such activities as apartment cleaning, grocery shopping, laundry, and help with grooming and meals. In the service market place these services are most often known as homemaker, chore and non-medical personal care. Not included are the personal care services provided by a home health aide or registered nurse.

For CHSP this is an "in-house" service. Shortly after it began, CHSP became a vendor for Ramsey County Community Human Services for the provision of housekeeping/personal care services. This means that CHSP participants can receive such services from a CHSP employee rather than from an outside vendor or two. Under this arrangement, CHSP is reimbursed for services provided to its participants who would ordinarily be covered by RCCHS. The difference is that the services are provided by CHSP employees and not by outside workers. If a participant needs more services than RCCHS will pay for, the services can be purchased by the participant from CHSP on the basis of a sliding fee scale. Also, if the participant is not eligible for any of these services from RCCHS, they pay CHSP on the sliding scale with CHSP receiving no reimbursement from RCCHS. Any shortfall between what is collected from the client and/or what is reimbursed by RCCHS is covered by CHSP's HUD funds. Participants are billed for any of these services by PHA along with their rent and meals.

CHSP's administrator thinks the provision of these services by CHSP employees rather than by outside vendors is better because 1) there are a limited number of workers who can get to know the participants because they are in the building five days a week, 2) the CHSP workers can perform both housekeeping and non-medical personal care services which might otherwise require two or more different workers from two or more outside vendors, 3) the service providers are CHSP employees responsible to the program only, and 4) these workers are able to perform on-going monitoring and feedback (while working in participant rooms or at meals) to the CHSP staff who do the case management.

For CHP participants these services are received in the same manner as someone living in a single-family dwelling or a non-CHP resident of the high-rise who receives services through the Hennepin County Department of Community Services (HCDCS) that are paid for by Title XX or the state's Alternative Care Grant program. Although a CHP client wanting homemaker and chore services usually gets just one worker from a single vendor, it is possible to have two workers from two vendors for these services and a home health aide from a third vendor. Having a home health aide is more likely for CHP participants because in Minneapolis neither homemaker nor home chore workers can do any non-medical personal care, whereas in St. Paul CHSP staff perform some non-medical personal care.

Hennepin County Department of Community Services assigns a Home Management Counselor to each CHP client who is eligible for homemaker or chore services. The Counselor arranges the service and monitors its provision. This is the same arrangement in effect for non-CHP eligible persons who receive these services.

While the provision of these services to CHP participants is the same as that provided to non-CHP clients, HCDCS has raised the income-eligibility levels for CHP clients. The income-eligibility limit for non-CHP individuals is $584 per month; for CHP participants it is $879 per month. In addition, CHP clients who have incomes above this limit can purchase services from HCDCS on a sliding-fee scale, something non-CHP clients are not permitted to do. To date about 10 CHP participants have taken advantage of these higher limits.

Counseling - Both prorgrams provide case management, which involves elements of counseling, and from time to time provide short-term counseling-type assistance, but neither becomes involved in long-term counseling or attempts to become extensively involved if moderate or severe mental health problems appear to be present. In the case of the latter, referrals are made to community agencies. Neither program has funds for this type of service.

Skilled Nursing Care - When the services of a registered nurse are required, both programs refer to community agencies. These services must be paid for directly by the client or through a third-party payer (e.g., Medicare or Medicaid). Neither program has a nurse on duty in the building--the programs are not designed for individuals who need constant nursing attention.

Home Health Aides - In a manner similar to the provision of skilled nursing services, home health aides may care for congregate housing clients. Here also the service comes from a community agency with neither program being involved in payment.

Transportation - Formalized transportation service is not provided by either program. However, as a part of the case management service participants are informed of available community services (Metro Mobility, reduced public transit fares) and referral assistance is given when a participant wants to utilize such service(s). On occasion program staff have been involved in transportation provision, but that is uncommon and the programs do not advertise themselves to their clients as a transportation service.

Socialization/Activities - The two programs differ in the provision of these services. CHP has a 20-hour-a-week Senior Aide whose only responsibility is to "organize and direct a social activities program" for CHP participants. (She is a retired Catholic nun who has worked as an activities director in a nursing home.) For CHSP participants their activities are those available to all of the residents of their buildings. In St. Paul this can sometimes amount to considerable activity because of the PHAs "adopt a high-rise" program whereby businesses and civic groups are recruited to provide activities for high-rise residents. (During the summer a St. Paul bank took residents of Ravoux to a Twins game.)

Both programs utilize the congregate meal setting as a time for socialization and some activities. As mentioned above, participants are discouraged from taking their meals in their own rooms. Also in both programs a "congregate housing community" has arisen within the buildings. This frequently entails looking out for each other and encouraging others to socialize.

Emergency Assistance - One aspect of this service is common to the two programs and one is not. The "I'm OK" program is in effect in all three buildings. This is a checking service whereby residents monitor each other through the placement of an "I'm OK" card on the outside of the apartment door. If the card fails to appear the resident is checked.

For CHSP residents, assistance can be summoned at any time by the use of an emergency cord in each apartment. When the resident caretaker is in the building, an alarm is sounded and the caretaker responds. When the caretaker is absent, a switch is thrown so that the call for help is received by paramedics based in the community. On occasion CHSP staff are summoned after hours and on weekends.

For CHP participants, there is a telephone number they can call at any time for emergency assistance. During the normal work week, the call is received by the CHP director, or, if he is out of the office, by a secretary in the Northside office of HCDCS's Services to Seniors unit. In the case of the latter, the CHP director can be reached by a pager which he carries with him. After normal work hours the call goes to the apartment of the resident Program Assistant. The Program Assistant then responds to the call. When he is off-duty one of the Program Aides receives the call and responds. CHP requires that all participants have a telephone and be capable of using it, although a few refuse to have a telephone. There are no emergency cords in Lyndale Manor.

Adult Day Care - Because the Amherst H. Wilder Foundation adult day care program is located at Ravoux, CHSP clients in that building are able to receive that service. Valley residents can participate only if transportation can be arranged.

For CHP clients to participate in adult day care, they must arrange transportation to leave their building.

Services Summary - In comparing the service provision of these two programs it is apparent that there are more similarities than differences. Where differences occur they tend to be in the organization of the service and not in the substance of the service provided. For both programs there is the provision of subsidized housing and case management services. Meals are available to all participants, although for CHSP there is 100% participation and most receive two meals a day instead of one a day. Participants of both programs can avail themselves of housekeeping, home chore, and non-medical personal care, although the organization and payment for these services differs substantially between cities. The provision of home health care is similar for both programs and both approach their clients' transportation in a similar manner. There are socialization and activities services available for all, but those in CHP have the services of a person specifically engaged to provide activities only for them. Both provide some counseling, but refer more difficult mental health situations to community agencies. Adult day care can be utilized, but much more easily by participants at Ravoux. Finally, both programs have emergency response systems in place, but they are handled differently.

SECTION EIGHT - DISCHARGED PARTICIPANTS

Data was collected from the termination files of both programs. In addition to the numbers of persons leaving, these data show the reasons for termination, the age and gender of each person, and the length of time each participant remained in the program. Discharges up until July 1, 1988 are included in this analysis.

Basic Frequencies

A. Number of Discharges. From the enrollment of its first participants in October, 1982, CHSP had 95 terminations. From the enrollment of its first participants in November, 1983, CHP had 36 terminations. The difference is due to 1) the year's head start CHSP had, and 2) the speed with which the programs added participants. CHSP reached its maximum enrollment by April, 1983 and remained at or near that level since. CHP was slower admitting participants and has never reached its maximum enrollment level of 60.

B. Gender. Twenty-four (66.7%) of the CHP discharges are female and 12 (33.3%) are male. For CHSP there are 56 females (58.9%) and 39 males (41.1%). Only small differences here.

C. Age at Termination. The mean average age (as of last birthday) for CHP is 74.61 and the median averge is 76. For CHSP the mean average age at discharge is 77.2 and the median is 78. (The standard deviations for the two programs are virtually the same: CHP = 10.7817; CHSP = 10.6287.) A breakdown by age category shows why the CHSP averages are somewhat higher than CHP's: 64.2% of CHSP's participants were above 75 years of age, while 52.8% of CHP's participants were in that range. (See Table 2.)

Table 2

Age Category for Discharges by Program

CHP			CHSP		
Age Category	No.	%	Age Category*	No.	%
Less than 60	3	8.3	Less than 60	7	7.4
60 - 64	4	11.1	60 - 64	6	6.3
65 - 74	10	27.8	65 - 74	21	22.1
75 - 84	10	27.8	75 - 84	34	35.8
85+	9	25.0	85+	27	28.4
	36	100.0		95	100.0

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* Termination data included all "permanent" participants regardless of age. CSHP from time to time admits persons who are considered temporary. Because the inclusion of their data would skew these results, that information has been omitted from this analysis.

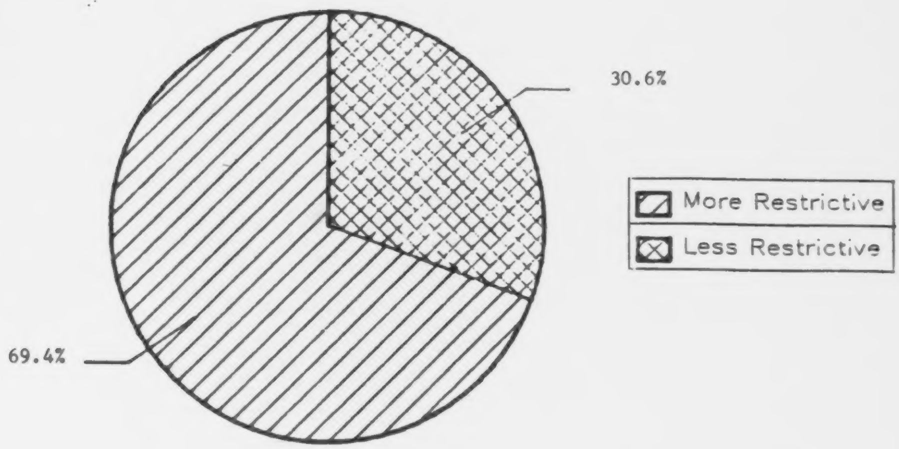
D. Reason for Leaving. Participants were classified by whether they left to a "less restrictive" environment or a "more restrictive" environment. The former included 1) leaving to live with a spouse or other relative, b) leaving to live with a non-relative, c) leaving to move out of the building alone, or d) withdrawing from the program but remaining in the building. The latter included: a) moving to a nursing home or other such more restrictive setting (in St. Paul this could mean discharge to the Wilder Assisted Living Program at Ravoux), b) discharge while in the hospital - this only occured if there was no expectation that the individual would return to the program (most subsequently were discharged to a nursing home or died in the hospital), or c) died while still living in the high-rise.

As can be seen in Figures 3 and 4 the percentages for the two programs are quite similar. CHP had 30.6% of its participants leave for less restrictive environments, CHSP had 23.2% leave for such environments. One interesting difference between the programs is that 19 (or 20%) of the former CHSP participants died, while only one (or 2.8%) of former CHP clients died while still in the program. The reason for this difference is not apparent from this data.

E. Time in the Program. Calculating the number of months a participant stayed in the program was somewhat problematic. Records did not always have the exact date a person entered or left the congregate housing programs. (This sometimes occured when the person entered the program having been a resident of the building immediately prior to program entrance.) Whenever a day of the month was missing or unclear, it was recorded as the 15th. (The value was recorded in increments of one-quarter of a month, e.g., 9.75 months, 13.25 months, and 48.0 months.)

The mean average number of months in the program for CHP is 16.44 and the median is 15. For CHSP the comparable figures are 16.82 and 13. The standard deviation for CHP is 10.75 and 15.25 for CHSP. This larger standard deviation for CHSP indicates that there is a wider distribution of scores around the mean than for CHP. A breakdown of months in the program by category explains the larger standard deviation for CHSP.

Figure 3
Reason for Leaving – CHP



Reason For Leaving – CHSP

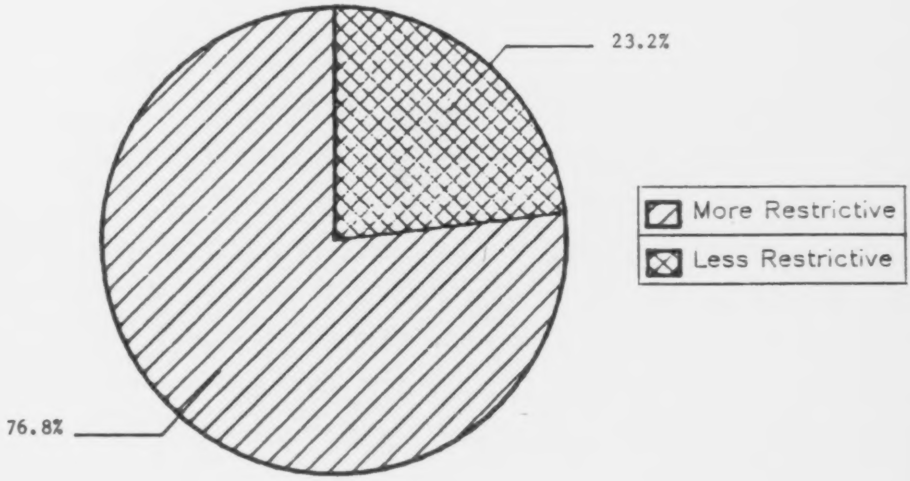


TABLE 5

Distribution of Time In The Program for Discharged Participants

CHP			CHSP		
Time Category	No.	%	Time Category	No.	%
Less than 3 months	0	0.0	Less than 3 months	21	22.1
3 mo. - 8.99 mo.	8	22.2	3 mo. - 8.99 mo.	17	17.9
9 mo. - 17.99 mo.	16	44.4	9 mo. - 17.99 mo.	20	21.1
18 mo. - 29.99 mo.	8	22.2	18 mo. - 29.99 mo.	18	18.9
30+ months	4	11.1	30+ months	95	20.0
	36	100.0		95	100.0

In Table 5 it is seen that 22% of the former CHSP participants left before they had been in the program for three months. There are no CHP clients who left prior to three months. The reason for this difference is not obvious from the data available. As mentioned above, there are slight differences in gender and age distributions between the programs, but the correlation coefficients between age and number of months in the program and gender and number of months in the program are low for both programs. In other words, neither age nor gender accounts for much of the variation in how long a person remained.

Additional Issues Explored

A. Are younger participants more likely to leave the program for a less restrictive environment? Yes. When age category is crosstabulated with reason for leaving, a moderately strong correlation coefficient (Cramer's V) is produced for both programs. For CHP it is .5800 and CHSP it is .4330. Table 6 shows the percentage for two age categories by whether or not the client left for a less or more restrictive environment. Note that the under 75 years of age group had a 58.8% and 47.1% chance of leaving for a less restrictive environment, while those 75 and over had only a 5.3% and a 9.8% chance of being discharged to a less restrictive environment.

TABLE 6

Age by Reason for Leaving by Program

CHP			CHSP	
Under 75	75+	Environment Type	Under 75	75+
58.8%	5.3%	Less Restrictive	47.1%	9.8%
41.2%	94.7%	More Restrictive	52.9%	90.2%

B. Is length of time in the program related to the reason for leaving? For example, are those participants who stay longer more likely to go to a more restrictive environment? Yes. As shown in Table 7, this is particularly true for those who stay at least nine months in CHP and for those stay at least three months in CHSP. (The 30+ category for CHP is contrary to this, but there are only four persons in that category.)

TABLE 7

Length of Stay by Reason for Leaving by Program

CHP

	Less than 3 months	3 mo. - 8.99 mo.	9 mo. - 17.99 mo.	18 mo. - 29.99 mo.	30+ mo.
Less Restrictive	----	50.0%	18.8%	25.0%	50.0%
More Restrictive	----	50.0%	81.2%	75.0%	50.0%

CHSP

	Less than 3 months	3 mo. - 8.99 mo.	9 mo. - 17.99 mo.	18 mo. - 29.99 mo.	30+ mo.
Less Restrictive	47.6%	23.5%	30.0%	11.1%	0.0%
More Restrictive	52.4%	76.5%	70.0%	88.9%	100.0%

C. Is one gender more likely than the other to leave to a less restrictive environment? No. Approximately the same percentage of females as males leave to a more restrictive environment and this applies to both programs.

D. Do the data suggest factors which lead some of the participants of CHSP to leave prior to three months? Yes and no. Age does not appear to be a factor. Of those who left prior to three months, 38.1% are under 75 years of age and of those who stayed at least three months 35.2% are under 75. Gender and functional ability appear to have some influence. Among those who left sooner, 52.4% are male, while among those who stayed longer only 37.8% are male. Also, among those who left prior to three months, 47.6% went to a less restrictive environment, while only 16.2% of those who stayed longer than three months went to a less restrictive environment. If it is assumed that it is the more functionally able participant who goes to a less restrictive environment, it can be said that it is the more functionally able male who tends to leave sooner.

SECTION NINE -- CURRENT PARTICIPANT CHARACTERISTICS

Even though both programs keep extensive records on each participant, using these records as a basis for comparing the programs is ill-advised. First, the records kept are not exactly the same in both cities. Second, even if the same records are kept, differences would certainly appear because different individuals were involved in gathering the information; this is particularly crucial when a judgment is called for on the part of staff. Third, it was discovered that while many of the files were complete as the participant entered the program, the most current information was not always available.

Instead of using data from current participant files, seven interviewers were hired to conduct a modified version of the Pre-Admission Screening (PAS) interview done in Hennepin County. (The instrument used for this study appears in Appendix A.) All interviewers were employed by that county's PAS office as PAS screeners. This reduced greatly the need for interviewer training and orientation. Because of a severe time constraint for collecting data and because good inter-rater reliability had been assured, random assignment of participants to the PAS screeners was foregone. The seven individuals simply divided the list of names among themselves so that the interviews could be completed in the shortest time.

Given the availability of $2,000 for the survey and a negotiated price of $25 per completed interview, 80 current participants could be interviewed. This was less than the total number of persons in the program at the time of the interviews - the first two weeks in July. Together the two programs had 98 participants. One method of reducing the number to be interviewed was to randomly select 40 from each program. However, this would undoubtedly have yielded several persons who were under 60, as both programs regularly admit such persons. This was an issue in this study because the Area Agency on Aging is primarily concerned about those who are at least 60 years of age (based on the Older Americans Act which provides their primary legislative mandate). A check of the ages of the current participants revealed that a decision to select only those at least 60 would yield 79 names - 43 from Minneapolis and 35 from St. Paul. Having a few more from CHP seemed acceptable as they had six additional clients. This selection method yielded 82.7% of the CHP participants (43 / 52) and 78.3% (36 / 46) of the CHSP participants. The final decision was to utilize those who were currently at least 60 years of age when they entered their program.

In preparation for the interviews each congregate housing program director prepared and sent to their respective participants a memo announcing that the program was cooperating with the Metropolitan Area Agency on Aging in conducting the survey and asked the participants to agree to be interviewed. Screeners attempted to contact their interviewees in advance by telephone. (In most cases they were successful. On a few occasions congregate housing staff were instrumental in making interview arrangements.) Before the interviews were conducted, the screener discussed the purpose of the study, informed the interviewees that they had the right to refuse to be interviewed, told them that the information would be kept confidential, and obtained their signature on the consent form.

Between the time the 79 names were identified and the time of the interviews, one person from CHSP was discharged to a nursing home. Two participants from CHP refused to be interviewed. Therefore, the CHP director was asked to assess these clients based on his knowledge of them. He was asked to complete only the portions of the instrument dealing with client demographics and functional abilities. He was not asked to complete the portion where the screeners made recommendations regarding the service needs, or the section which required the participant to demonstrate orientation and memory. Data from these two CHP participants were added to the survey dataset and are utilized in the subsequent discussions. However, there will only be 76 observations for some of the analysis because of the missing data for these two persons. This will be noted when it occurs.

Even though the screeners were utilizing a modified version of an instrument they use everyday in their work, they did not spend as much time as they normally would verifying information from the respondent or securing information from other sources which the respondent could or would not provide. For that reason the value of these functional assessments lies more in the provision of data on which to compare the programs than in providing valid indicators of the functional abilities of these congregate housing participants. Because participants tend to overestimate their abilities, these data are considered conservative indicators of the true functional abilities of the program clients.

Frequencies for Demographics.

First, a look at the basic characteristics of the participants from each program. Appendix B contains the frequency distributions for all the variables discussed in this segment.

This is a gender difference for current participants greater than that found for the termination data and this time it is CHSP with a higher percentage of females. The CHSP percentages are 74.3% female and 25.7% male; for CHP the figures are 69.5% female and 39.5% male.

The mean average age for CHSP is 80.66 with a median of 81; for CHP the mean is 75.33 and the median is 76. Both programs have a similar distribution of ages at the upper end of the age spectrum: CHSP has about 23% of its participants who are at least 85, while about 21% of the CHP participants are in that age range. The 5-plus difference in means arises because CHP has about 19% of its participants between the ages of 60 and 65, while CHSP has only 3% within that range.

The distribution of participant race is fairly similar: CHSP is 94.3% white and CHP is 86.0% white.

The distribution of current marital status is relatively similar with the exception of the category "widowed." There are 68.6% of CHSP clients in this category and 51.3% of CHP clients in this category.

Prior living arrangement shows some differences between programs. While CHSP has 48.6% who lived alone prior to entering the program, the figure for CHP is 60.5%. The other category where there is a noteable difference is in the percentage who previously lived with relatives. For CHSP it is 31.4 and for CHP it is 20.9.

Type of dwelling previously lived in shows that 52.9% of CHSP participants indicated they previously lived in a house; the comparable figure for CHP is 37.2%. Notice the category for those who indicated they entered their program from some type of institution. For CHSP it is 2.9% and for CHP it is 9.4%.

These data conflict with information from the program files. Of the 35 CHSP participants interviewed, six or 17.1% came from nursing homes or other institutional setting according to client records. According to CHP records, seven of the 35 interviewed, or 16.3%, entered from a nursing home or other institution. These discrepancies may reflect client's memory problems or an unwilingness to admit they had been confined to such an environment.

Medicaid status is difficult to compare because for more than 20% of those in CHP the screener was not able to determine this status. They were instructed not to take the extra time to discover the status if the interviewee did not know. Based on this self-reported data, CHSP has a lower rate of Medicaid participation: CHSP has 22.9% and CHP has 33.3%. If even one-third of the nine "don't knows" for CHP are enrolled in the program, that would raise the CHP rate to 40%.

Functional Ability Frequencies.

Appendices C-1 and C-2 present the frequencies for the functional ability variables addressed by the survey. The survey instrument (in Appendix A) shows that data for these 22 variables was collected according to four or five subcategories respresenting increasing levels of functional disability. Frequencies are reported here, however, according to a recoding of these variables into just two categories. One category indicates the interviewer thought that the participant had "no disability," and the other category is for when there was at least "some disability" noted. While detail is lost thereby, the utilization of dichotomous variables makes interpretation much easier.

There are two general groupings of variables. One grouping will be referred to as ADLs (aids to daily living) and the other as IADLs (instrumental aids to daily living). The gerontological literature[1] defines the former as basic self-care skills such as bathing, eating, toileting, dressing, walking, and grooming. IADLs are generally defined as more complex activities such as cooking, cleaning, doing laundry, managing money, and utilizing transportation. This dataset contains 15 ADLs and 7 IADLS.

The ADLs. There are eight variables in this group where there is little or no difference between the programs regarding the percentages who have no difficulty--refer to Appendix C-1. (Little or no difference is defined as less than 10% difference between programs in the percent who have no problem.) They are: dressing, bed mobility, transferring in and out of bed, walking, wheeling, hearing, vision, and behavior. The remaining seven variables all indicate that the CHP participants are better off (i.e., CHP shows a higher percentage who have no problem). These ADLs are: bathing, eating, communicating, orientation, toileting, and self-preservation. The most noteworthy differentials occur for grooming, bathing, and self-preservation where the differences are 25%, 31.5%, and 21.2% respectively.

The IADLs. There are four variables in this grouping which evidence little or no difference between the programs in the percentage who have no difficulty--refer to Appendix C-2. They are: housekeeping, self-medication, transportation, and concept of danger. The three where there is a difference of at least 10% are telephone use, handling finances, and food preparation. Here the differences are 11.4%, 24.4%, and 24.5% respectively. For all three variables it is the CHP participants who have less difficulty.

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[1] Kane, R.A., (1985). Assessing the Elderly Client. In Monk, A. (Ed.). Handbook of Gerontological Services (pp. 43-69). New York: Van Nostrand Reinhold Company.

ADL - IADL Summary. Out of 22 variables, 13 show differences so small as to be unimportant for our present purposes. For each of the nine variables with a noteable difference between the two programs, the data indicate that the CHSP participants are more functionally disabled. For the 13 variables where there are only small differences, 11 of the comparisons show that CHSP has a higher level of functional disability. The conclusion is clear: congregate housing participants in St. Paul tend to be more disabled than their counterparts in Minneapolis.

The variable daily living score was created by summing the values for all 15 ADLs and all 7 IADLs. Because these 22 variables were all coded 'zero' if there was no problem and 'one' if there was a problem, the daily living score could have a minimum value of zero and a maximum value of 22. The former occurs when there are no problems indicated for any of the ADLs and no problems indicated for any of the IADLs. The latter occurs when there is some problem indicated for all 15 of the ADLs and all 7 of the IADLs. The frequency distributions are shown in Table 8 for each program. The mean average daily living score for CHSP participants is 9.31, with a median of 8. The mean average daily living score for CHP participants is 6.60, with a median of 6. This differential (which shows that the CHSP clients are, in general, more disabled) does not come about, of course, because all CHSP participants are more disabled than any of the CHP participants. It comes about primarily because CHP has more participants who received low daily living scores, indicating few problems. As seen in Table 8, 20.9% of the CHP clients have 10 or more problem ADLs and IADLs, while 34.3% of the CHSP clients are in that range. This is not a large difference. But, when the lower range of the distributions are compared it is seen that there are many more with few problems enrolled in CHP than in CHSP. Over one-third of the CHP participants (37.2%) are rated as having 5 or less problem ADLs and IADLs. For CHSP there are only 5.7% in that range. One might speculate that if CHP had been operating at maximum capacity--as CHSP has been--it might have the luxury of being more selective at intake and consequently its mean daily living scores would be higher, reflecting a client group that is more disabled.

TABLE 8

Daily Living Score Frequencies by Program

CHP

SCORE	FREQUENCY	PERCENT
1	2	4.7
2	3	7.0
3	4	9.3
4	5	11.6
5	2	4.7
6	7	16.3
7	7	16.3
8	1	2.3
9	3	7.0
10	3	7.0
11	2	4.7
12	2	4.7
14	1	2.3
18	1	2.3

CHSP

SCORE	FREQUENCY	PERCENT
3	1	2.9
4	1	2.9
6	3	8.6
7	10	28.6
8	5	14.3
9	3	8.6
10	1	2.9
11	3	8.6
13	1	2.9
14	1	2.9
15	3	8.6
16	2	5.7
17	1	2.9

Orientation and Memory Test.* The survey instrument contains questions which allow the calculation of a score which measures the time orientation and memory of the respondent. The maximum score of 27 indicates no incorrect answers. The minimum possible score is zero. The mean average score for CHSP clients is 21.03, with a median of 22.5 and a standard deviation of 6.43; for CHP the mean is 21.59, the median 24 and the standard deviation of 5.74. Clearly this test suggests no overall difference between the programs regarding orientation and memory.

Screener Assessments.*

Based on the interview, each screener is to make several recommendations regarding the respondent. First, there is a recommendation concerning "where" the client should reside: at home or in a nursing home. If the recommendation is to reside at home, there is also a recommendation whether or not the client needs services--see Appendix D. One person from CHP (2.4%) received a recommendation for nursing home placement and two (5.7%) from CHSP received that recommendation. There is a substantial difference between the programs regarding the recommendation that the individual be "at home without services." Twenty-two percent of the CHP participants received this recommendation, but only 2.9% of the CHSP clients did. The remainder in each program received a recommendation for being "at home with services": 75.6% for CHP and 91.4% for CHSP. These recommendations are consistent with the comparisons made for ADLs and IADLs.

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* Only 41 CHP participants.

Second, the screeners made a recommendation regarding specific levels of care according to the following categories: 1) not at risk, 2) ICF II, 3) ICF I, 4) SNF, and 5) hospitalization--see Appendix D. (ICF refers to intermediate care facility with level II requiring less care than level I. SNF refers to skilled nursing facility.) As the numbers get higher the level of care is greater. It is noteworthy that 26.8% of the participants in CHP received a "not at risk" rating but no one from CHSP received such a rating. Percentages for ICF I and ICF II are similar, but there is a sizeable difference for the SNF rating, with 4.9% of the CHP clients receiving this rating and 17.1% of the CHSP clients obtaining this rating. Again, these ratings are consistent with ADL and IADL results.

Finally, each screener assigned a Case Mix Letter according to a scheme developed for all PAS assessments in the state--see Appendix D. The letters range from A to K with the level of severity of the functional disability being higher the further down the alphabet. (An "A" would have fewer problems than a "D.") There is little variation in letters for all the congregate housing participants with over 80% being assigned a rating of "A." There is a slight difference in percentage receiving an "A" between the programs, with 87.8% from CHP and 74.3% from CHSP.

Income.

Because the screeners were instructed not to contact sources other than the respondent for income information and because many persons were unsure of their financial situation, the data collected is not considered valid and is not reported. It is safe to say that an ovewhelming majority of participants have annual incomes well below the PHA maximum of $22,700.

Recommended Services.*

For each participant interviewed the screener listed any services believed to be needed. Sometimes services from family members or volunteers were listed. These informal services are not addressed in this report, instead only those services provided by formal service agencies are discussed.

A total of 12 services were recommended at least once. Table 9 presents a listing of these services along with the number and percentage of participants for whom each service was recommended. For CHSP the two services most frequently recommended are meals and homemaker services with 85.7% of the participants receiving the former recommendation and 60% receiving the latter recommendation. The next four in terms of frequency recommended are: day care, combined homemaker/home health aide, transportation, and case management. The respective percentages are 37.1, 34.3, 31.4, and 28.6.

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* Only 41 CHP participants.

TABLE 9

Recommended Services by Program

CHP*			CHSP	
No.	% of Participants	Service	No.	% of Participants
1	2.4%	Nursing Home+	2	5.7%
26	63.4	Meals+	30	85.7
22	53.7	Homemaker+	21	60.0
1	2.4	Home Health Aide+	4	11.4
14	34.1	Combined Homemaker/ Home Health Aide	12	34.3
2	4.9	Registered Nurse+	4	11.4
2	4.9	Case Management	10	28.6
4	9.8	Day Care+	13	37.1
24	58.5	Transportation	11	31.4
0	0.0	Mental Health+	1	2.9
10	24.4	Lifeline+	4	11.4
10	24.4	Senior Companion	3	8.6

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* Only 41 participants.
+ Services for which cost estimates were recorded.

For CHP the two most frequently recommended services are meals and transportation with 63.4% of the participants receiving the former recommendation and 58.5% receiving the latter recommendation. The next four in terms of frequency recommended are: homemaker, combined homemaker/home health aide, Lifeline, and Senior Companion. The respective percentages are: 53.7, 34.1, 24.4, and 24.4.

After omitting the one participant for whom a nursing home was recommended, a total of 115 formal services were recommended for the 40 CHP clients. This is a mean average of 2.9 services per client. For CHSP, a total of 113 services were recommended for 33 clients yielding a mean of 3.4 services per client, after omitting the two persons who received nursing home recommendations. This larger amount for CHSP is consistent with the ADL and IADL comparisons discussed above.

It was noted in Section Seven that 100% of the CHSP participants received meals and that only 21 or 22 CHP participants did. Because it is not known how many ~~of~~ these 21 or 22 were interviewed (remember that not all current participants were interviewed), the proportion of respondents receiving meals cannot be stated. But, at most a little over 50% of the respondents received meals (22 / 41), while the screeners recommended that over 60% needed them. The contrary is true of CHSP: screeners recommended that about 85% needed meals, yet 100% receive them.

Service Costs.*

For each service listed the screener was to indicate 1) how many hours per day the service was needed, 2) how many days a week the service was needed, and 3) an estimated cost for that service per month (see Appendix A, page 87.) If a homemaker is needed one hour a day, three days a week at $10 per hour, the cost estimate would be $120 (1 hour per day x 3 days per week x 4 weeks per months x $10 per hour = $120). For some services it is not possible to accurately estimate the cost--for example, transportation. Even though the screener could reasonably assume such help is needed, it is not possible to predict how many times a week someone might ride public transit at a reduced fare or utilize Metro Mobility. Similarly, reasonable costs for case management and Senior Companion could not be estimated. See Table 8 for those services for which a cost estimate was recorded.

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* Only 41 CHP participants.

A total service cost value was calculated for each respondent by summing the amounts listed for the recommended services. The mean average total service cost per month for CHSP is $546.23. For CHP the mean total service cost per month is $338.71. The difference between these means is considerable--$202.52 - and reflects the greater incidence of functional disability for CHSP clients discussed above.

A closer look at the recommended service data, however, suggests a strong bias among the screeners which may make these total service cost figures misleading when used to compare the two programs. The service in question is meals. There is evidence to suggest strongly that the screeners had a tendency to recommend what the participant was utilizing rather than making recommendations based on their assessments--the latter is how they were instructed. As explained above in Section Seven, at Lyndale Manor CHP participants can get, at most, one meal a day, seven days a week. In fact, only 10 residents currently take seven meals a week and only 21 or 22 (out of 52) take even one meal a day, five days a week. A CHP client who wants two meals a day, seven days a week cannot get them through the congregate housing program. On the other hand, at Ravoux and Valley, all or nearly all of the participants take two meals a day, seven days a week.

There are three basic meal patterns among the programs: 1) one meal a day, five days a week, 2) one meal a day, seven days a week, and 3) two meals a day, seven days a week. Note the pattern frequencies in Table 10. The tendency to recommend according to the program pattern available is strongly suggested by this data. Only three times out of a total of 56 meal recommendations did a screener recommend a pattern unavailable to the participant.

TABLE 10

Meal Pattern Frequencies by Program

CHP			CHSP	
No. of Times Recommended	% of Time Recommended	Pattern	No. of Times Recommended	No. of Times Recommended
8	30.8	1/day, 5 day/wk	0	0.0
15	57.7	1/day, 7 day/wk	0	0.0
3	11.5	2/day, 7 day/wk	30	100.0
26	100.0		30	100.0

Meal costs were a significant proportion of the total service costs. For all participants, meals were a mean average of 30.0% of the total services. (For CHSP, meals were a mean average 35.5% of participant's total service costs. For CHP, meals were a mean average 25.3% of the total service costs.) Because meals figured so prominently in the total service cost calculations and because screener bias is strongly suspected in relation to meal recommendations, a revised total service cost was calculated for each participant by subtracting the meal cost from the original total service cost.

The resultant revised total service cost for the two programs was not as far apart as the total service cost. The mean average revised cost for CHSP is $412.17. The mean average revised cost for CHP is $268.78. The differences between the means is now $143.39, instead of a difference of $213 for the original total service costs. This differential still reflects a greater incidence of functional disability among CHSP participants.

The reader is reminded that these cost estimates do not include such service costs as housing, case management and transportation. Accordingly, they should not be used to compare costs between congregate housing programs and other service arrangements (e.g., nursing homes).

SECTION TEN -- COMPARATIVE SUMMARY OF PROGRAMS

This section will make summary comparisons between the Congregate Housing Services Program in St. Paul (CHSP) and the Congregate Housing Program in Minneapolis (CHP). This discussion is based on the material presented in sections one through nine of this report. While important differences exist, the programs have similar goals, organizational auspices, service packages, intake processes, and their current and former clients are relatively similar.

Need and Purpose. A common denominator for both programs is the involvement of each city's public housing authority. Accordingly, it is not surprising that the PHAs' concerns about the increased age of their elderly residents and the accompanying increasing inability to live independently served as crucial focal points for the efforts which eventually led to the creation of these two congregate housing programs. In both cities, service organizations shared the PHAs' concerns about the aging-in-place, inappropriate institutionalization of older persons, and the increasing costs for the care of the functionally disabled. At the time these two programs were being developed, both PHAs were also concerned about the vacancy rates in their elderly high-rises.

Commonality is found in the substantive aspects of the programs, due, in part, to the Congregate Housing Services Program Act of 1978. Regulations from such federal initiatives have a way of becoming "starting points" for those developing such programs, regardless of whether or not the sponsors receive funding from the federal government.

Similarities are seen in the announced goals for each program. In its grant application to HUD, the PHA of the City of St. Paul stated:

> The goal of the proposed ... CHSP shall be to prevent premature or unnecessary institutionalization of elderly and handicapped residents by:
>
> 1. Providing for the nutritional needs of CHSP participants by serving two meals a day, seven days a week.
> 2. Providing housekeeping assistance to participants in those areas where they are unable to adequately perform housekeeping tasks.
> 3. Providing personal assistance to program participants who demonstrate difficulty in carrying out the functions of eating, bathing, grooming and dressing.
> 4. Providing expanded personal counseling services to program participants presenting emotional and/or family problems due to losses experienced in the normal process of aging.
> 5. Providing for the limited extension of existing transportation services to enable program participants with physical and mental impairments to meet their medical appointments, and
> 6. Facilitating optimal utilization of CHSP services, and the qualitative extension of existing services through professional case management and coordination of supportive services for CHSP participants.

The goals for the Congregate Housing Program in Minneapolis are reflected in this statement which appeared in final report of the Congregate Housing Facility Planning Committee:

> The purpose of the committee was to develop a proposal for a program to meet the needs of persons currently having difficulty living independently and in need of some form of housing which would include supportive services, i.e., congregate housing. Congregate housing would enable the MPHA to more safely house these individuals, serving as a resource for semi-dependent residents who require a higher level of supportive services and more supervision than the average high-rise resident but not the level of services provided by a nursing home. It would also save some

> residents who are still capable of semi-independent living from the difficult adjustment and negative effects of moving to a nursing home, board and care facility, or to the home of family members. In addition, congregate housing would save County dollars by limiting inappropriate nursing home placement and perhaps preventing or delaying the need for more expensive forms of care such as board and lodging, approximately $1,000/month, or skilled nrusing home care, over $1,500/month. The proposed program would provide services that maintain individuals at a maximum level of independence but would facilitate additional care if they become more disabled, receiving decreasing services if they improve, leaving the program if they improve to a point where they can function independently, or moving to alternative living arrangements if their needs can no longer be handled within the environment. "Extended independent living" would be the major objective of this program.

Organization. There are several aspects of each program's organizational structure which is similar. The involvement of that city's public housing authority is one. In St. Paul the program is entirely under the auspices of the PHA, in Minneapolis the program is a joint venture of the PHA and the county social services department. Both programs are small components of large organizations. In terms of budget and/or staff and/or number of clients, each program is dwarffed by its parent organization. Another similarity is the use of other service agencies to assist in program management (e.g., the Professional Assessment Committees) and to serve congregate housing participants. These linkages to the community are crucial in both programs and require on-going coordination.

The major dissimilarity lies in the joint auspice of the Minneapolis program. The CHP director is responsible through the chain of command in the Hennepin County Department of Community Services to the county Board of Commissioners, while the physical facilities are under the control of the Minneapolis Public Housing Authority, an element of city government. Even though CHP is a joint operation, the director did not identify as problematic trying to serve two agencies. Indeed, it appears that there is very little formal contact between the two sponsoring agencies regarding the program, with contact coming primarily between the CHP director and the caretaker at Lyndale Manor.

Facilities. Because both programs operate in public housing high-rises for the elderly, the physical environments are quite similar. All program offices (one for CHP and two for CHSP) are located in these high-rises with the respective PHAs providing, also without charge, additional space for the crucial meals programs and related activities.

The size of the participants' apartments and the appliances/equipment are essentially the same.

Personnel. Both CHSP and CHP have full-time directors and that is about where the similarities end. CHSP has a staff person who acts somewhat like an "assistant director," while CHP is limited to one full-time employee--the director.* Both programs rely heavily on part-time staff, but the composition, duties, and compensation for these individuals varies greatly. The part-time staff at CHP are all residents of Lyndale Manor who receive an hourly wage of $1.00 per hour when "telephone sitting" in relief of the Program Assistant who normally operates the emergency response system, and at or slightly above minimum wage for other duties performed; all are older persons. The CHSP part-time staff, on the other hand, are much younger and are paid about twice the hourly wage paid to the CHP aides. The duties for the CHP aides are concentrated in the emergency response system, while at CHSP these individuals provide a variety of services to participants including housekeeping, laundry, grocery shopping, and some non-medical personal care.

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* This excludes the Program Assistant who might be considered full-time by virtue of the number of hours worked. However, his primary responsibility is to the emergency response system and not to other aspects of CHP.

Another similarity is in the utilization of Senior Aides and Senior Companions. For both programs these workers are provided by community agencies and would appear in a budget as in-kind.

The responsibilities of the respective directors are very similar: overall program management, staff supervision, and case management.

Funding. Trying to discover financial and other resources utilized by these programs is problematic.

CHSP has direct control over a much greater amount of money because of its HUD grant. It also has a much more complicated financial situation due to 1) its status as a vendor for its county's social services department for the provision of housekeeping/non-medical person care services, and 2) the collection and disbursement of meals income and the collection of payments for housekeeping and personal care. Excluding in-kind, during the last four quarters, CHSP has utilized about $170,000 worth of resources versus about $52,000 for CHP. Certainly the accounting services needed are quite different in the two cities.

With the exception of small amounts of money for weekend meals, CHP directly controls only the assets of its live-in Program Assistant, who operates the emergency response system, several part-time, non-professional aides who provide ancillary program support, and the director.

Both programs benefit from large amounts of in-kind resources, yet these resources are not consistently or adequately chronicled.

Admission Processes. The area in which there is the greatest similarity is the process by which a participant is admitted. There are common standards and priorities established for admission, as well as similar forms and procedures utilized. Both rely heavily upon the advise of a Professional Assessment Committee for admission and demission. In both, the applicant begins the process by filing for residency with the PHA.

One difference is that CHP does its in-person assessment with the prospective client at Lyndale Manor, while CHSP normally does its in the home of the applicant. Another difference is that CHP recently began to add a medical assessment by an RN (in the person's home) to its process.

Service Supports. This is another program component which is very similar. All participants have available to them: housing, case management, housekeeping, personal care, nursing services, transportation, counseling, activities and an emergency response system. The primary differences pertain to involvement of the program in the organization of and payment for the services. CHSP is much more involved than CHP.

There are some differences in how the emergency response system operates and how and for whom activities are organized.

Terminations. Because of its longer tenure and its ability to reach maximum enrollment soon after inception, CHSP has discharged nearly three times the clients as CHP. The gender mix of those leaving the two programs is similar, but CHSP participants are older as a group than those in CHP.

In general, the reasons participants "left" the program are similar. About 70 to 75 percent of those leaving went to a more restrictive environment than their congregate housing program. The major difference in reasons for leaving lies in the fact that 20% of the CHSP clients died while still in the program and only one person (2.8%) did so while in the CHP program.

The mean average number of months a participant remained in her or his program is essentially the same--about 16.5 months. However, there is a substantial difference in the percentage from each program who left prior to remaining in the program three months. Over 20% of CHSP participants left prior to remaining that long and none of the CHP clients left prior to three months.

Participant Characteristics. Participants who were at least 60 years of age on July 1, 1988 were interviewed to ascertain their demographic characteristics, functional ability levels, need for various services, and service costs. The two program populations are similar in that they are older, possess multiple disabilities relating to aids to daily living and instrumental aids to daily living, and have the need for several supportive services, including housing. The cognitive functioning levels for CHSP and CHP clients are the same.

Participants in the two programs differ on several items. First, the CHSP group is older than the CHP group. On the average they are about five years older. Second, gender and incidence of widowhood are different. CHSP has a higher percentage of females (74.3% versus 69.5%) and a corresponding higher proportion of widows. Third, CHSP clients tend to be more functionally disabled. Of the 22 functional abilities assessed, current CHSP participants have, on the average, at least some problem with 9.3 daily living tasks, while the same figure for CHP participants is 6.6. Fourth, in keeping with their greater incidence of difficulty with the daily living tasks, CHSP clients are seen as needing more services. The interviewers recommended, on the average, 3.4 services for CHSP clients and 2.9 services for CHP clients. Fifth, consistent with their greater need for services, CHSP participants need greater financial resources for their services. According to the service recommendations of those who interviewed the current congregate housing participants, CHSP participants require services costing nearly $150 per month more than do CHP participants.

SECTION ELEVEN -- CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

In this section, the investigator will present conclusions, discuss implications, and make some recommendations to the Metropolitan Area Agency on Aging regarding possible future actions pertaining to congregate housing in the Twin Cities area.

Conclusions

A. The two congregate housing programs studied both appear to "work." Each has been successful over a period of years in developing a means to effectively package services for a group of older persons who might have been forced prematurely into more restrictive and more costly environments. The heavy reliance on housing, meals, housekeeping/ personal care, and case management is very appropriate. Both programs are appropriately aware of the primacy of the case management function.

B. These two programs are meeting a real need, especially for lower-income older persons. (Because only these two programs were studied, and because both operated in public high-rises, conclusions cannot be offered outside this area.) These programs are particularly successful in meeting needs of residents of the respective bulidings as they age-in-place. Many current participants have joined the program without the need to relocate. A related conclusion is that neither program has been very successful in attracting residents of other public housing high-rises. Even though program planners initially expected a substantial pool of applicants from other high-rises, this has not occured. One reason for this lack appears to be a misunderstanding about what congregate housing can do for high-rise residents over and above what can be done for them in their present location.

C. Neither model is clearly superior to the other. The fundamental reason for this conclusion is that the two programs are more alike than they are different. Individual aspects of each might be promoted as superior to the other, but overall the programs are very similar. If a judgment is made regarding the ability to construct a program utilizing local resources, CHP would be better. If a judgment is made regarding the ability to construct a program without relying primarily on local resources, CHSP is better. If simplicity of organization is the issue, CHP would be better. If the issue is ability to control, and therefore better coordinate, a wide variety of services, then CHSP is superior. However, if the question pertains to overall superiority, the answer is difficult to determine. Depending on one's perspective, a different program might emerge as "better" each time a different question is raised.

D. The Public Housing Authority of the City of St. Paul and the Minneapolis Public Housing Authority have both been successful in adopting the accomodating housing model. While the respective programs have not been successful in attracting residents from other high-rises they have been able to continue serving residents of Lyndale Manor, Ravoux Hi-rise, and Valley Hi-rise who might otherwise have left to more restrictive environments. The conclusion is that public housing authorities can be appropriate sponsors of congregate housing. There are two obvious advantages: 1) PHAs have the potential clients, and 2) they have the housing resources to commit to the program. Once an older person has become a resident in a public housing elderly high-rise, there is much less disruption to their lives when they remain in the current surroundings than if they had to move into a high-rise and, at the same time, become a congregate housing client.

Implications

The Twin Cities area can take advantage of what can be learned from these two programs. These congregate housing "successes" have demonstrated that somewhat different organizational and administrative arrangements can lead to a provision of services that appears to work for the client. One lesson to be learned from this is that there is no correct way to organize and provide congregate housing and that local conditions can be accomodated if there is a genuine desire to offer congregate housing services.

Another lesson learned is that if residents of various high-rises are to be served, it might be necessary to have programs in various high-rises. The program in St. Paul appears to have learned that lesson, when, about one year ago, they transferred one-half of their program slots to Valley Hi-rise. This investigator is forced to wonder if the Minneapolis program might not have reached its maximum of 60 clients if it had decentralized its program to other buildings. The Ravoux-Valley experience seems to indicate that programs can be run at satellite or outreach locations from a central office without incurring additional burdensome administrative expenses.

Neither program attempted to serve persons with significant behavioral or medical problems. That would seem to be wise counsel if other programs are initiated. Neither program offers on-going nursing services and does not claim to be able to serve clients that need this care. Likewise, they do not accept individuals who have behavioral problems which would require an excessive amount of staff services to monitor and control.

The experience in Minneapolis (and to a lesser extent in St. Paul) has shown that given appropriate housing resources, a congregate dining program, and the availability of housekeeping/personal care and home health services, the missing ingredients necessary to produce a successful congregate housing program appear to be case management and administrative services. Specifically, someone must assess the needs of the clients; determine if congregate housing is the needed service; "package," coordinate, and monitor services; and perform whatever administrative duties are required. CHP has utilized one person for this, while CHSP has used more than one.

Recommendations

There is definitely a role for the Metropolitan Area Agency on Aging (AAA) regarding the future of congregate housing in the Twin Cities area and I recommend strongly that they consider accepting this challenge.

The legislative mandates of the Older Americans Act for area agencies on aging regarding 1) the development of a comprehensive, coordinated system of services, 2) responsibilities to help fill service gaps, 3) the goal of promoting the independence of older persons in the community, as well as 4) the new initiatives under Title III-D all indicate the appropriateness of the Metro AAA serving as a focal point for continued discussions about the efficacy of congregate housing.

The AAA's direct control of the allocation of funds for social services, meals and the new frail initiatives (Titles III-B, C & D of the Older Americans Act) puts it in the very desirable position of being able to "put its money where its mouth is" as it works with other agencies and attempts to get them to commit their resources.

In addition, the AAA is well-suited to take a leadership position regarding congregate housing because of the stature of the Metropolitan Council. The Council is recognized as a legitimate and competent planning agency. Also, as a planning body, the AAA cannot be accused of promoting its own services, because it does not provide direct services to clients.

More specifically, in accepting the challenge to take the leadership in the development of additional congregate housing services, it is recommended that the Area Agency on Aging:

A. Develop a formal plan. In order to plan properly, evidence should be gathered and analyzed to specify the amount of unmet need which could be addressed by congregate housing. For example, MPHA has has 5,150 units for elderly and handicapped in 42 high-rises. About 71% of those units are occupied by persons who are at least 62 years of age--their definition of elderly. Thirty-six percent of this 62 and over group are at least 80 years of age. Also, an MPHA official pointed out that 41% of those under 62 and handicapped--the other category of residents in these high-rises--are in their 50s. These individuals will be "elderly" within the next ten years or so and may well need services such as congregate housing long before most older persons because of their disabilities. Furthermore, MPHA notes a rise in the proportion of elderly applicants with disabilities. Sixty percent of all new applicants who are 62 or older have at least one disability. Given a mean average age of current "elderly" high-rise residents of almost 75 years, a large "handicapped" population in their 50s, and an increasing proportion of "elderly" applicants with disabilities, an unmet need could be concluded.

(Similar information is compiled in "Social Service Needs in Public Housing Hi-Rises," a report issued by the Public Housing Agency of the City of St. Paul in May, 1988.)

Following the development of a formal statement of unmet need, objectives should be established (e.g., number of clients to be served), site locations determined, staffing plans and budgets developed, plus a strategy to secure the needed resources.

B. Include Public Housing Authorities as sponsors or co-sponsors. Both CHSP and CHP have clearly demonstrated the importance of the involvement of the PHAs. The public housing authorities in both cities are to be commended for their efforts in the development and operation of the existing programs and for their indications of willingness to consider expanding their programs. In addition to the necessary housing resources, they possess valuable knowledge of how to operate such a program. They also have within their other high-rises many potential clients for expanded congregate housing services.

C. Commitment of AAA Resources. The area agency should be willing to commit some of its own service funds. Some of these resources could be allocated as start-up or seed money and some on a more permanent basis (e.g., funds for congregate dining sites). Those community agencies who might contribute resources to the expansion of congregate housing services will undoubtedly be more inclined to add their resources to the pool if the agency taking the leadership--the AAA--has also agreed to contribute.

D. Seek to develop new services with a minimum of new resources. Given the unlikelihood of increasing funding for such programs from government sources (at least in the short run), it is recommended that a model for local congregate housing be developed based on the lessons from the organization and financing of the congregate housing program in Minneapolis. From CHP it is learned that 1) significant, new, outside funding is not a pre-requisite, 2) public agencies--even those from different geopolitical entities--can cooperate in sponsoring a successful congregate housing program, and 3) it is possible to run such a program with few organizational changes.

E. Utilize a decentralization model for services. Both CHSP and CHP learned that few high-rise residents will move to another high-rise in order to join a congregate housing program. CHSP demonstrated that taking the congregate housing program to the potential clients (as they did at Valley Hi-rise) is workable. It is recommended that any efforts to expand these services into other PHA high-rises be smaller and decentralized. Consideration should given to congregate housing satellites of 15 to 25 participants, depending in the economics of various sites. CHSP submitted a proposal (unsuccessful) to the Robert Wood Johnson Foundation for the development of satellite CHSPs throughout the city. Elements of that proposal should be conisdered as a starting point for the development of an appropriate model.

F. Imaginative ways to package and deliver housekeeping and personal care services. The operation of the housekeeping and personal care services as done by CHSP has the advantage of centralizing the delivery of these services. However, it has the disadvantage of requiring considerable administrative resources to operate. Because both the Hennepin County Department of Community Services and the Ramsey County Community Human Services have shown their willingness to cooperate by making special arrangements for clients of congregate housing programs, possibly a way could be found to declare a "vendor monopoly" for congregate housing clients so that any confusion caused by multiple vendors in the same building could be avoided. Utilizing existing vendors would make it unnecessary for the congregate housing program to become so heavily involved in the administration of the services as is done in St. Paul with CHSP.

APPENDIX A

Congregate Housing Study

INTERVIEWEE NAME____

SCREENER NAME______________________ INTERVIEW DATE__________

GENDER M F

DATE OF BIRTH________________

AGE_________

MARITAL STATUS_______ SELECT FROM: S=single, never married, D=divorced, W=widowed, M=married living with spouse, P=legally separated, V=involuntarily separated, U=unknown

ETHNIC GROUP________ SELECT FROM: B=Black, I=Native American, P=Pacific Islander, S=Hispanic, SE=Southeast Asian, W=White, O=Other

INCOME by source and amount (enter amount, a blank will mean a zero for that category)

SOCIAL SECURITY $______________per month

SSI $______________per month

MSA $______________per month

RAILROAD RETIREMENT $______________per month

VETERANS BENEFITS $______________per month

INTEREST $______________per month

OTHER1 $______________per month

OTHER2 $______________per month

OTHER3 $______________per month

Appendix A (continued)

LIVING SITUATION IMMEDIATELY BEFORE ENTERING CHP/CHSP?

(Check one)

___ alone
___ with spouse
___ with relatives
___ with nonrelatives(s)
___ other, specify______________
____

(Check one)

___ house/duplex
___ apartment; non-public housing
___ public housing
___ nursing home
___ other institution, specify__________
____

__________ * DRESSING

0..Dresses Without Help of Any Kind
1..Needs & Receives Supervision/Program
2..Needs & Receives Help From Another
3..Is Dressed (Unable to Participate)
4..Never Dressed

__________ * DRESSING

0..Grooms Self Without Help of Any Kind
1..Needs & Receives Supervision/Program
2..Needs & Receives Help From Another Daily
3..Is Groomed

__________ * BATHING

0..Bathes Without Help of Any Kind
1..Needs & Receives Minimal Supervision
2..Needs & Receives Supervision Only
3..Needs & Receives Help In & Out Tub
4..Needs Personal Help Washing/Drying Body
5..Is Bathed (Unable to Participate)

__________ * EATING

0..Feeds Self Without Help of Any Kind
1..Needs & Receives Minimal Supervision
2..Needs Personal Assistance From Staff
3..Needs Partial Feeding From Another
4..Needs Total Feeding From Another Person

__________ * BED MOBILITY

0..Moves Self In Bed Without Help
1..Needs Occasional Help From Another
2..Always Needs Help From Another To Sit UP
3..Needs Turning & Positioning

---

* Case Mix ADLS

Appendix A (continued)

__________ * TRANSFERRING

0..Transfers Without Help Of Any Kind
1..Needs Guidance Only - Anothers Presence
2..Needs Physical Aid Of One Person
3..Needs Aid of Two Persons or Device
4..Remains Bedfast

__________ * WALKING

0..Walks Without Help Of Another Kind
1..Needs the Help of a Device (cane, walker)
2..Needs the Personal Help of One Person
3..Needs the Personal Help of Two Persons
4..Unable to Walk

__________ WHEELING

0..Does Not Use Wheelchair/Receives No Help
1..Needs Help Negotiating Doorways, Ramps
2..Needs Total Help With Wheeling

__________ COMMUNICATION

0..Communicates Needs
1..Communicates Need With Difficulty
2..Communicates With Sign Language, Writing
3..Communicates Inappropriate, Garbled
4..Does Not Communicate Needs

__________ HEARING

0..No Hearing Impairment
1..Hearing Difficulty at Level Conversation
2..Hears Only Loud Sounds
3..No Useful Hearing
4..Not Determined

__________ VISION

0..Has No Impairment of Vision
1..Has Difficulty Seeing at Level of Point
2..Has Difficulty Seeing Obstacles
3..Has No Use Vision
4..Not Determined

---

* Case Mix ADLS

Appendix A (continued)

__________ ORIENTATION

0..Oriented
1..Minor Forgetfulness
2..Partial/Intermittent Period Disorientation
3..Total Disoriented
4..Comatose
5..Not Determined

__________ BEHAVIOR

0..Behavior Requires No Intervention
1..Occasional Intervention/Responds to Cues
2..Needs Regular Intervention/Re-Direction
3..Disruptive/Needs Behavior Management
4..Physically Abusive/Needs Behavior Management

__________ * TOILETING

0..Independent
1..Needs Help to Toilet, No Incontinence
2..Occasional Incontinence, Not More 1/Week
3..Nocturnal Incontinence Only
4..Incontinent Bladder, More Than Once A Week
5..Incontinent Bowel, More Than Once A Week
6..Incontinent Bowel & Bladder

__________ SELF PRESERVATION

0..Independent
1..Minimal Supervision
2..Mentally Unable
3..Physically Unable
4..Both Mentally & Physically Unable

---

* Case Mix ADLS

Appendix A (continued)

ORIENTATION AND MEMORY TEST

What month is it? (1 point) _____ X 3 = _____

What time is it? (1 point) _____ X 4 = _____

What year is it? (1 point) _____ X 3 = _____

Remember these three items:
TABLE, PENNY, APPLE

Count backwards from 20 (2 points correct, 1 point off for one mistake only) _____ X 2 = _____

Recite the months of the year backward (2 points correct, 1 point off for one mistake only) _____ X 2 = _____

Memory recall (1 point for each correct) _____ X 3 = _____

TOTAL _______________
(maximum score = 27)

Appendix A (continued)

SELF PRESERVATION SKILLS

These items are appropriate only for clients currently living at home. This information can be obtained from client but should be verified whenever possible. Choose the answer that best describes the person's function in the last month or NA (not applicable):

Ability to Use Telephone	1 Operates on own initiative, never needs assistance.	2 Dials well-known numbers, needs help with new numbers.	3 Answers phone only.	4 Unable to use phone.	NA
Finances	1 Manages independently, pays bills, goes to bank.	2 Manages ordinary purchases, but needs help balancing check book or paying bills.	3 Sometimes needs help for simple purchases; unable to pay bills correctly.	4 Incapable of handling money.	NA
Housekeeping (e.g., laundry, cleaning)	1 Maintains house alone.	2 Light tasks only, needs help with heavy cleaning, or not as neat as at one time but mostly acceptable.	3 Some light tasks can be carried out but, overall unacceptable level of cleanliness.	4 Unable to maintain house without extensive daily assistance.	NA
Food Preparation	1 Plans, prepares and serves own meals.	2 Prepares adequate meals but cannot shop for groceries by self.	3 Able to cook simple meals but does not maintain adequate diet.	4 Unable to prepare food at all.	NA
Medications	1 Responsible and able to administer to self.	2 Will take if laid out weekly.	3 Will take if laid out daily.	4 Must be administered by others.	NA
Transportation	1 Drives self; able to travel independently.	2 Can drive, travel on own, but afraid or unwilling.	3 Must be driven, but can travel.	4 Does not travel.	NA

Appendix A (continued)

	1	2	3	4	5
Concept of Danger	Adequate regard or no opportunity for contact with appliances, cars, cigarettes (recognizes hazard).	Instances of disregard for safety in operating appliances, machines, driving, or careless smoking (some incident 1/month) weather-inappropriate dressing.	An incident occurs about twice/month.	An incident of disregard for safety. Once/week.	Unable to recognize hazards, dangers at any time.

Appendix A (continued)

PRE-ADMISSION SCREENING RECOMMENDATION

(Check One)

____ Nursing Home
____ At home with services
____ At home without services
____ Other, specify____________________

LEVEL OF CARE

(Check One)

____ Not at risk
____ ICF II
____ ICF I
____ SNF
____ Hospital

CURRENT MEDICAL ASSISTANCE STATUS

(Check One)

____ Yes
____ No
____ Don't know

RECOMMENDED SERVICES -- Includes both 'formal' and 'informal'

	Type of Service	Hours/Day	Days/Week	Cost
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10				

CASE MIX LETTER _____

APPENDIX B

Demographic Frequencies

PROGRAM = CHP			PROGRAM = CHSP		
GENDER	FREQUENCY	PERCENT	GENDER	FREQUENCY	PERCENT
Female	26	60.5	Female	26	74.3
Male	17	39.5	Male	9	25.7

AGE	FREQUENCY	PERCENT	AGE	FREQUENCY	PERCENT
LT 65	8	18.6	LT 65	1	2.9
65-74	9	20.9	65-74	4	11.4
75-84	17	39.5	75-84	22	62.9
85+	9	20.9	85+	8	22.9

RACE	FREQUENCY	PERCENT	RACE	FREQUENCY	PERCENT
Non-white	6	14.0	Non-white	2	5.7
White	37	86.0	White	33	94.3

CURRENT MARITAL STATUS	FREQUENCY	PERCENT	CURRENT MARITAL STATUS	FREQUENCY	PERCENT
Divorced	7	16.3	Divorced	4	11.4
Legally Separated	3	7.0	Legally Separated	0	0.0
Single Never Married	10	23.3	Single Never Married	6	17.1
Involuntarily Separated	1	2.3	Involuntarily Separated	1	2.9
Widowed	22	51.2	Widowed	24	68.6

Appendix B (continued)

PROGRAM = CHP

WITH WHOM LIVED	FREQUENCY	PERCENT
Alone	26	60.5
With Spouse	5	11.6
With Relative	9	20.9
With Nonrel	3	7.0

TYPE OF FACILITY	FREQUENCY	PERCENT
House/ Duplex	16	37.2
Apartment Nonpub	15	34.9
Public Hsng	8	18.6
Nursing Home	2	4.7
Other Instit	2	4.7

MEDICAL ASSISTANCE	FREQUENCY	PERCENT
Yes	14	33.3
No	19	45.2
Don't Know	9	21.4

PROGRAM = CHSP

WITH WHOM LIVED	FREQUENCY	PERCENT
Alone	17	48.6
With Spouse	6	17.1
With Relative	11	31.4
With Nonrel	1	2.9

TYPE OF FACILITY	FREQUENCY	PERCENT
House/ Duplex	18	52.9
Apartment/ Nonpub	9	26.5
Public Hsng	6	17.6
Nursing Home	1	2.9
Other Instit	0	0.0

MEDICAL ASSISTANCE	FREQUENCY	PERCENT
Yes	8	22.9
No	25	71.4
Don't Know	2	5.7

APPENDIX C-1

AIDS TO DAILY LIVING

PROGRAM = CHP

DRESSING

ADL1	FREQUENCY	PERCENT
No Problem	40	93.0
Some Problem	3	7.0

GROOMING

ADL2	FREQUENCY	PERCENT
No Problem	39	90.7
Some Problem	4	9.3

BATHING

ADL3	FREQUENCY	PERCENT
No Problem	32	74.4
Some Problem	11	25.6

EATING

ADL4	FREQUENCY	PERCENT
No Problem	38	88.4
Some Problem	5	11.6

BED MOBILITY

ADL5	FREQUENCY	PERCENT
No Problem	41	95.3
Some Problem	2	4.7

PROGRAM = CHSP

DRESSING

ADL1	FREQUENCY	PERCENT
No Problem	31	88.6
Some Problem	4	11.4

GROOMING

ADL2	FREQUENCY	PERCENT
No Problem	23	65.7
Some Problem	12	34.3

BATHING

ADL3	FREQUENCY	PERCENT
No Problem	15	42.9
Some Problem	20	57.1

EATING

ADL4	FREQUENCY	PERCENT
No Problem	26	74.3
Some Problem	9	25.7

BED MOBILITY

ADL5	FREQUENCY	PERCENT
No Problem	32	91.4
Some Problem	3	8.6

Appendix C-1 (continued)

PROGRAM = CHP

TRANSFERRING FROM BED

ADL6	FREQUENCY	PERCENT
No Problem	42	97.7
Some Problem	1	2.3

WALKING

ADL7	FREQUENCY	PERCENT
No Problem	16	37.2
Some Problem	27	62.8

WHEELING

ADL8	FREQUENCY	PERCENT
No Problem	38	88.4
Some Problem	5	11.6

COMMUNICATION

ADL9	FREQUENCY	PERCENT
No Problem	41	95.3
Some Problem	2	4.7

HEARING

ADL10	FREQUENCY	PERCENT
No Problem	31	72.1
Some Problem	12	27.9

PROGRAM = CHSP

TRANSFERRING FROM BED

ADL6	FREQUENCY	PERCENT
No Problem	32	91.4
Some Problem	3	8.6

WALKING

ADL7	FREQUENCY	PERCENT
No Problem	10	28.6
Some Problem	25	71.4

WHEELING

ADL8	FREQUENCY	PERCENT
No Problem	30	85.7
Some Problem	5	14.3

COMMUNICATION

ADL9	FREQUENCY	PERCENT
No Problem	27	77.1
Some Problem	8	22.9

HEARING

ALD10	FREQUENCY	PERCENT
No Problem	22	62.9
Some Problem	13	37.1

Appendix C-1 (continued)

PROGRAM = CHP

VISION

ADL11	FREQUENCY	PERCENT
No Problem	27	62.8
Some Problem	16	37.2

ORIENTATION

ADL12	FREQUENCY	PERCENT
No Problem	28	65.1
Some Problem	15	34.9

BEHAVIOR

ADL13	FREQUENCY	PERCENT
No Problem	37	86.0
Some Problem	6	14.0

TOILETING

ADL14	FREQUENCY	PERCENT
No Problem	39	90.7
Some Problem	4	9.3

SELF PRESERVATION

ADL15	FREQUENCY	PERCENT
No Problem	14	32.6
Some Problem	29	67.4

PROGRAM = CHSP

VISION

ADL11	FREQUENCY	PERCENT
No Problem	19	54.3
Some Problem	16	45.7

ORIENTATION

ADL12	FREQUENCY	PERCENT
No Problem	16	45.7
Some Problem	19	54.3

BEHAVIOR

ADL12	FREQUENCY	PERCENT
No Problem	27	77.1
Some Problem	8	22.9

TOILETING

ADL14	FREQUENCY	PERCENT
No Problem	26	74.3
Some Problem	9	25.7

SELF PRESERVATION

ADL15	FREQUENCY	PERCENT
No Problem	4	11.4
Some Problem	31	88.6

APPENDIX C-2

INSTRUMENTAL AIDS TO DAILY LIVING

PROGRAM = CHP

PHONE USE

IADL1	FREQUENCY	PERCENT
No Problem	32	80.0
Some Problem	8	20.0

FINANCES

IADL2	FREQUENCY	PERCENT
No Problem	24	55.8
Some Problem	19	44.2

HOUSEKEEPING

IADL3	FREQUENCY	PERCENT
No Problem	7	16.3
Some Problem	36	83.7

FOOD PREPARATION

IADL4	FREQUENCY	PERCENT
No Problem	13	30.2
Some Problem	30	69.8

MEDICATION

IADL5	FREQUENCY	PERCENT
No Problem	35	92.1
Some Problem	3	7.9

PROGRAM = CHSP

PHONE USE

IADL1	FREQUENCY	PERCENT
No Problem	24	68.6
Some Problem	11	31.4

FINANCES

IADL2	FREQUENCY	PERCENT
No Problem	11	31.4
Some Problem	24	68.6

HOUSEKEEPING

IADL3	FREQUENCY	PERCENT
No Problem	3	8.6
Some Problem	32	91.4

FOOD PREPARATION

IADL4	FREQUENCY	PERCENT
No Problem	2	5.7
Some Problem	33	94.3

MEDICATION

IADL5	FREQUENCY	PERCENT
No Problem	29	90.6
Some Problem	3	9.4

Appendix C-2 (continued)

PROGRAM = CHP

TRANSPORTATION

ADL6	FREQUENCY	PERCENT
No Problem	0	0.0
Some Problem	43	100.0

DANGER CONCEPT

IADL7	FREQUENCY	PERCENT
No Problem	40	93.0
Some Problem	3	7.0

PROGRAM = CHSP

TRANSPORTATION

IADL6	FREQUENCY	PERCENT
No Problem	2	5.7
Some Problem	33	94.3

DANGER CONCEPT

IADL7	FREQUENCY	PERCENT
No Problem	29	85.3
Some Problem	5	14.7

APPENDIX D

SCREENER ASSESSMENTS

PROGRAM = CHP

RECOMMEND	FREQUENCY	PERCENT
Nursing Home	1	2.4
At Home With Services	31	75.6
At Home No Services	9	22.0

CARELEVEL	FREQUENCY	PERCENT
Not At Risk	11	26.8
ICF II	12	29.3
ICF I	16	39.0
SNF	2	4.9

CASEMIX	FREQUENCY	PERCENT
A	36	87.8
B	3	7.3
C	0	0.0
D	2	4.9
E	0	0.0
F	0	0.0

PROGRAM = CHSP

RECOMMEND	FREQUENCY	PERCENT
Nursing Home	2	5.7
At Home With Services	32	91.4
At Home No Services	1	2.9

CARELEVEL	FREQUENCY	PERCENT
Not At Risk	0	0.0
ICF II	14	40.0
ICF I	15	42.9
SNF	6	17.1

CASEMIX	FREQUENCY	PERCENT
A	26	74.3
B	4	11.4
C	2	5.7
D	0	0.0
E	2	5.7
F	1	2.9

PREPARED STATEMENT OF

SUPPORTIVE SERVICES COMMITTEE

WESTCHESTER COUNTY OFFICE

AGING ADVISORY COUNCIL

White Plains, NY

We at the Westchester County Office for the Aging were pleased to learn that the House Select Committee on Aging is concerned with the problems which arise out of the 'aging-in' of seniors in government subsidized housing. This is a problem which is brought to our attention daily through the calls we receive from seniors in these housing developments.

During the past several years, the Housing and Supportive Services Subcommittees of the Westchester County Office for the Aging Advisory Council have been looking at the problems associated with the "aging-in" of tenants in apartment complexes, both subsidized and non-subsidized, and their need for supportive services to permit them to continue living within their communities. Tenants who do not have housing subsidies face the additional financial problems associated with ever increasing rents and incomes which do not rise to meet their ever increasing expenses.

Subsidized housing for the elderly has, for the most part, been built to provide affordable housing for senior citizens. Senior citizens living in these buildings where their rent is tied to a fixed percent of their income,can tell you how lucky they are. So can the many thousands whose names are on waiting lists for entry to this type of housing.

While most buildings included apartments for residents with disabilities, a community room and an on-site management office, senior housing was not constructed with supportive services as part of the housing package. The services available to these residents depends upon the management and the surrounding community. Now that seniors are "aging-in-place", the need for services to enable these older residents to remain in the community and thus delay institutionalization has become apparent.

Institutionalization is the most costly living arrangement, not only in terms of finances, but in human terms as well. For most seniors, the longer we can delay institutionalization, the more money we can save and the happier the frail senior will be. In a housing study carried out some years ago it was noted that seniors tended to indicate to their management that they were more capable than they actually were so that they would not become candidates for nursing home placement. This is a sad commentary on the nursing home industry and on the limited options which we in America make available to our most frail and dependent citizens.

It is in the best interest of all of us -- senior citizens, junior citizens, elected officials and the housing and aging services industries -- to help provide the services which will keep us together in the communities in which we desire to live at a cost we can afford to pay.

While it is true that there are programs such as enriched housing, which bring services to seniors in goverment subsidized buildings, by and large there is no formal system which can help the senior as she or he deteriorates and is increasingly in need of assistance. We talk of a "continuum of care", yet we do not provide the leadership in setting up the human and humane systems we need. It is our sincere hope that your committee can help to create the climate and provide the guidelines and the funding so desperately needed.

In this era of fiscal constraint on all levels -- from the senior citizen to the municipality, the County, the State and the Federal government -- we have tried, in making our recommendations, to suggest changes which will provide a more comprehensive range of needed services in the most cost effective and efficient manner.

The services which need to be provided on-site include home care, on-site medical and other social services, entitlement counseling, friendly visiting and/or telephone reassurance, case management assessment and follow-up, health screening and counseling, banking, recreation and advocacy services. With little financial investment, we can coordinate and bring services to those seniors who are unable to go out and get them.

Why not use the community room in senior housing to permit local nurses, doctors, banks, podiatrists, case managers, entitlement counselors, representatives of the local Social Security Administration and Department of Social Services to spend a few hours or days each month on the premises in response to the needs of the residents. All clients in the building could be seen on the same day, by appointment. If the clients have home care workers and use special transportation, this system would save money.

As one of the first needs is for simple assistance with shopping and carrying packages, why not have a local market bring their merchandise to the building and sell it from their truck or van? A close second is for help with transportation perhaps to the supermarket or the doctor or just to be outdoors with nature or other people. With coordination, trips can be scheduled for several residents at a time, a cost savings too.

We would like to propose that your committee consider the following suggestions for legislation:

1. Government subsidized housing should mandate and provide funding for support services, such as home care, congregate housing services, and a live-in home care superintendent.

The live-in home care superintendent should be responsible for overseeing the care given to residents by home care workers in order to make certain that the plan of care specified for the resident is being followed and to report any irregularities to the appropriate parties. S/he should also serve as back up if the regular aides do not show up. The home care superintendent should have an apartment in the building and be on call for emergencies.

2. Funding should be earmarked for case management services to be provided by a staff person trained in gerontology and/or social work.

3. All buildings should have special apartments for 3-4 residents which can be used as shared living dwelling for frail elderly who can no longer live independently. This would delay institutionalization and keep seniors in their preferred environment, among friends, as they become less able to care for themselves.

4. Travelling service teams should be funded by the government to go to senior housing on a weekly or bi-weekly basis to bring needed care and to provide assessments of frail elderly resident's needs. Teams should include a nurse, social worker and home care aide.

5. Legislation should be passed to provide for sliding fee scale for supportive services. Currently only payment method is Medicaid or private pay.

6. Arrangement should be made to bring services to senior housing. For example, on a monthly basis, banking, health screening, entitlement counseling by DSS and AAA staffs and advocacy, podiatry provided by local agencies, nursing school, hospital staff and other service providers could use an office or community room to provide needed services to seniors.

7. Funds should be made available and training mandated, including in-service and on-going training, to sensitize management and maintenance staffs to the problems of seniors and to symptoms associated with normal and abnormal aging.

8. All senior housing should be set up with Emergency Response Systems of some type, either connected to local hospital or police or emergency medical services team or other 24-hour provider of emergency medical care.

9. Tenant Councils should be mandated with specific responsibilities for programming. Funds for this should be set aside as well.

10. Use of "shared aide" concept so that one aide may provide service to several residents on any given day. In our County we call this "Cluster Home Care" and find that it is not only cost effective and worker efficient but that it raises the professional status of the worker. The home care worker comes in, does what needs to be done that day and then leaves -- just as the physical therapist, nurse and others do now. This requires a higher per hour salary (or a weekly wage) and a worker who enjoys her job. It gains for the worker a higher status and prevents the situation where the client complains that the worker just watches TV. The increased hourly cost is more than offset by the more efficient use of the worker's time.

11. Home delivered meals or meals prepared on site, with perhaps a kitchen for congregage meals and delivery of meals to homebound residents in their apartments.

12. Residents in studio apartments needing live-in care should have priority for 1 bedroom apartments.

13. Crime prevention education, including fundamentals of self defense for residents as well as increased police presence in areas which are 'drug' areas, with management responsible for reporting incidents to local authorities.

14. Pet policy should be extended to ensure that management does not place unreasonable requests on residents, such as high security deposits for having a pet, which counteracts spirit of the legislation and discourages pet ownership.

15. Legislation to mandate that management contact "third party" -- family, AAA or local DSS -- if client is late with rent payment. Client may be in hospital or may be deteriorating or in financial trouble with lateness a symptom of need for attention and assistance.

16. Legislation to ensure that new regulations regarding priority clients for residency do not bring problems into senior housing that may be alcohol or drug related without mandating special supportive services for such clients.

17. Special attention and protection to be given to seniors living in intergenerational housing units in high crime areas.

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We hope that this first step which the House Select Committee on Aging has taken will result in legislation which will help us all focus on the need to help the frail elderly, as much and as little as possible, to remain in their homes and communities for longer than it is now possible. We believe tht those involved with housing and with serving the elderly can work together to make all this possible.

Thank you for allowing us to share our thoughts and suggestions with you.

EXECUTIVE SUMMARY

A Cost Comparison of Congregate Housing and Long-Term Care Facilities In The Midwest

HOUSING RESEARCH & DEVELOPMENT PROGRAM
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

PREPARED FOR:
ILLINOIS HOUSING DEVELOPMENT AUTHORITY

SEPTEMBER 1985

This study was commissioned in the spring of 1985 by the Illinois Housing Development Authority and conducted by the Housing Research and Development Program at the University of Illinois. The purpose of the study was to determine if there are significant cost savings to the elderly residents of Illinois and to the state if those elderly, capable of assisted, independent living, were to be provided congregate housing rather than accommodation in long-term care facilities.

In Illinois, licensed long-term care facilities include nursing homes and homes for the aged. Both facility types are designed to provide long-term care for the chronically frail and ill who are incapable of independent living.

Congregate housing consists of independent apartments for elderly residents with chronic functional disabilities who are still capable of maintaining a private apartment with supportive assistance. Residents live independently but receive at least one major meal served in a congregate dining hall each day, and have the option of receiving assistance with additional meals, housekeeping, personal care, transportation and other support services. Unlike a long-term care facility, no professional staff such as nurses, therapists, or social workers are stationed on-site in congregate house. Only the congregate dining, and in some cases housekeeping, is provided by on-site staff. All other services are brought in to meet individual resident support requirements as needed. Residents requiring extensive and long-term nursing and personal assistance cannot be accommodated in congregate housing.

Studies of the elderly population reveal that, of the approximately 20 percent who suffer chronic functional dependencies, more than two-thirds can live out their lives with the level of assisted independent living provided by congregate housing, while less than one-third ever require long-term dependent living arrangements. Between 20 and 30 percent of the elderly who eventually reside in long-term care facilities are people who could live in congregate housing were such facilities available.

This study is one of the most carefully controlled, comparative cost analyses of congregate housing and long-term care facilities undertaken to date. Seven congregate housing and seven long-term care facilities, which were the most representative of facilities in urban areas of the Midwest and Illinois respectively, were selected for site visits and in-depth analysis of housing and support service costs. The study sites were chosen from a careful stratification of existing facilities using characteristics critical to the cost comparison analysis. Costs were collected from the congregate housing sites first. Then, with the levels of support dependencies in congregate housing known, costs for housing and support of elderly with comparable support dependencies were collected at the long-term care facilities. For purposes of this study, the actual cost comparisons were based on long-term care facility residents classified or requiring either sheltered or intermediate care.

A number of cost comparisons were made utilizing different assumptions about a number of factors including the age and capital cost of the facility, the method of reimbursement (public or private), and the level of the resident's functional ability. These comparisons demonstrated cost savings attributable to congregate housing which ranged from $300 per resident per year to $6,072 per resident per year. The researchers have concluded that the two following scenarios represent the most likely cost savings to be realizable through congregate housing:

Scenario 1. When comparing the costs incurred by the actual mix of private pay and public aid residents in the long-term care facilities studied, to the actual rents and service fees paid by the comparable residents of congregate housing, congregate housing produced a cost savings of $1,320 per person per year, or $195,000 for the average-sized congregate facility per year.

Scenario 2. The savings shown in Scenario 1 are considered a conservative estimate because the congregate facilities tended to be built after 1980 and the long-term care facilities before 1970. This results in higher capital costs and debt service for congregate facilities. Normalizing capital costs and debt service to 1985 for all facilities results in a fairer comparison and simulates a cost for facilities being built and occupied in 1985. With normalized capital costs and debt service, congregate housing produced a cost savings of $4,233 per person per year and $630,000 for the average facility.

If the elderly residents in question are public aid eligible, the cost savings with congregate housing to the state are significant. The type of long-term care resident most likely to be eligible for congregate housing is the resident defined as receiving sheltered care. Unlike the costs for more dependent levels of long-term care (intermediate care and skilled care), sheltered care costs are not reimbursed by the federal Medicaid program. Reimbursement for these costs is on a grant basis through the general revenue fund for the State of Illinois.

The *quantifiable* cost savings with congregate housing are significant. In addition this study found numerous quality of life factors which favor congregate housing but cannot be quantified when comparing assisted independent living with dependent care. For the costs incurred, the average congregate housing resident is receiving 400–500 square feet of private apartment compared to 100–150 square feet of semi-private space around a bed in a nursing institution. Unlike most long-term care facility residents, congregate housing residents retain control of their money, their personal affairs, their daily routine and the freedom to come and go as they please. Congregate housing promotes self-sufficiency, encourages cost-saving interdependence with friends and neighbors in the community, offsets social isolation and introduces costly professional support services only at the margin of individual need. For all these reasons, congregate housing is a timely and important housing option for the State of Illinois.

EXECUTIVE SUMMARY

The Retention and Transfer of Frail Elderly Living in Independent Housing

HOUSING RESEARCH AND DEVELOPMENT PROGRAM
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

PREPARED FOR:

ILLINOIS HOUSING DEVELOPMENT AUTHORITY
ILLINOIS DEPARTMENT OF PUBLIC AID
ILLINOIS DEPARTMENT ON AGING

AUGUST 1987

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of Illinois and
Illinois Housing Development Authority

EXECUTIVE SUMMARY

Illinois is faced with a rapidly growing population of elderly, many of whom may be at risk of losing their independent housing due to advanced frailty, specific functional disabilities, or a lack of adequate support. This study focused on the elderly already in the support network of the [illegible] those residing in subsidized housing for the elderly and Medicaid recipients living in the community. This study was conducted by the Housing Research and Development Program of the University of Illinois - at Urbana/Champaign for the Illinois Housing Development Authority, the Illinois Department of Public Aid, and the Illinois Department on Aging. These three agencies [illegible] commissioned this research because it involves housing finance, social welfare, and social support issues, and interdepartmental cooperation will be required if the growing needs and costs of supporting the frail elderly in Illinois are to be adequately addressed in future program planning and implementation.

The purpose of this study was twofold: 1) to estimate the size of the subsidized population at risk of losing their independent housing; and 2) to suggest policy and program development to assist the population's effort to age-in-place with adequate support. Some of the specific questions pursued by this study included: how many elderly are already beyond the definition of independent living; how the dependence of the elderly is monitored and their support needs are met; when and how the elderly are transfered/evicted; and what changes in the physical design and management operations of the facilities surveyed are necessary if the residents are to be housed in the most efficient and appropriate environment for their support needs. These and other questions were answered by analyzing responses to surveys mailed to a 25% sample of subsidized housing managers and 100% of their residents, and a 6% control population of Medicaid recipients. The response rates for all three surveys were very high for mail-out/mail-back surveys.

Numerous measures were included in the survey to estimate the number of subsidized housing residents at risk of losing their independent housing. The primary definitions chosen for future planning purposes are based on the managers' estimates of residents who frequently or always have difficulty completing independent activities of daily living and whether or not they receive assistance with the activities. Managers' estimates of these measures were collected for eleven different independent activities and yielded estimates of the percentages of residents at risk ranging from 2.5% to 18.2%, depending on the difficulty level of the activity. Survey responses indicated that responding Medicaid recipients are even more vulnerable to the risk of losing their functional independence than are subsidized housing residents, with percentages of those at risk ranging from 2.3% to 20.4% Survey results also indicated that the inappropriate retention of elderly in their current environments may even be a greater problem than that of the risk of inappropriate transfer.

The study explored three policy/program alternatives based on the survey results. These alternatives are: 1) a laissez-faire approach; 2) development of an explicit housing owner policy on transfer/retention and provision of the staff training and visiting service coordination necessary to achieve the policy; and 3) conversion of some or all facilities to subsidized congregate housing to allow residents to age-in-place or construction of new subsidized congregate housing. The study concludes that of the three alternatives, conversion to congregate housing is the most appropriate means to extend the ability of elderly residents to live independently.

A copy of the full 266-page study, The Retention and Transfer of Frail Elderly Living in Independent Housing, is available for $15 from: The Illinois Housing Development Authority, Marketing, Research, and Planning Secretary, 401 N. Michigan, Chicago, IL 60611. Phone: (312),836-5370. Make checks payable to the Illinois Housing Development Authority.

EXECUTIVE SUMMARY

The Retention and Transfer of Frail Elderly Living in Independent Housing

HOUSING RESEARCH AND DEVELOPMENT PROGRAM
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

PREPARED FOR:

ILLINOIS HOUSING DEVELOPMENT AUTHORITY
ILLINOIS DEPARTMENT OF PUBLIC AID
ILLINOIS DEPARTMENT ON AGING

AUGUST 1987

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of Illinois and
Illinois Housing Development Authority

EXECUTIVE SUMMARY

Illinois is faced with a rapidly growing population of frail elderly and, at the same time, a rapidly growing cost of support services and skilled care. From 1980 until the year 2,000, the elderly population in Illinois over age 62 is expected to grow by 13% (from 1,557,748 to 1,760,255), but this is dwarfed by the growth of the population of more vulnerable elderly age 75 and older, a group which will increase by 52% (from 500,402 to 760,611). Demand for long-term support services, both in care facilities and community based, will increase dramatically.

This report focuses on elderly already in the support network of the state, residing in subsidized housing for the independent elderly and Medicaid recipients living in the community. The research issues and findings are designed to estimate the number of elderly in these subsidy groups at risk of losing their independent housing or being inappropriately retained in a housing environment that cannot adequately support them due to advanced frailty.

The primary policy focus is on the subsidized housing environment for independent elderly. The study seeks to determine how many elderly are already beyond the definition of independent living, how their dependence is monitored and their support needs are met, when and how they are transferred/evicted, and what changes in the physical design and management operations of these facilities are necessary if the residents are to be housed in the most efficient and appropriate environment for their support needs.

Illinois had an estimated 73,399 subsidized apartments for the elderly and handicapped as of 1983/84; 61,324 of these units (83.6%) are in new construction/purpose built facilities, and 45,386 (61.8%) of these new construction facilities are located in the 23 metropolitan counties. These 45,386 units make up the 304 subsidized housing facilities that comprise the study universe in this report. Seventy-six of these facilities (25%) were selected for analysis via random sampling. In the Spring of 1986 surveys were mailed to the 25% sample of subsidized housing managers and 100% of their residents, and a 6% sample of Medicaid recipients.

Of the 76 housing managers surveyed, 64 responded (84.2%); of the 10,437 subsidized housing residents surveyed, 5,627 responded (53.9%); and of the 2,461 noninstitutionalized active Medicaid recipients surveyed, 1,156 responded (46.9%). Of the total Medicaid recipients surveyed, 2,046 were from the 23 metropolitan counties being studied, and 888 responded (43.4%). These are very high response rates providing reliable yet conservative estimates of elderly at risk of losing their functional independence.

The study was conducted by the Housing Research and Development Program at the University of Illinois for The Illinois Housing Development Authority, The Illinois Department of Public Aid, and The Illinois Department on Aging. These three agencies have joined together to finance this research because it involves housing finance, social welfare and social support issues, and interdepartmental cooperation will be required if the growing needs and costs of supporting the frail elderly in Illinois are to be adequately addressed in future program planning and implementation.

THE PERCENTAGE OF SUBSIDIZED ELDERLY AT RISK OF LOSING THEIR INDEPENDENCE

The managers of subsidized housing predict that 12.4% of their residents will have to move to a more dependent environment within a year. This is an increase from 11.1% average of actual moves to more dependent care plus deaths in the previous year.

Numerous measures were included in the survey to estimate the number of subsidized housing residents at risk of losing their independent housing. The primary definitions chosen for future planning purposes are based on the managers' estimates of residents who frequently or always have difficulty completing independent activities of daily living, and managers' estimates of residents who frequently or always have difficulty and receive no help. Receiving no help implies a very serious and immediate risk of losing an independent apartment or being inappropriately retained in an apartment. Managers' estimates of these measures were collected for 11 different independent living activities. Three activities, housekeeping, personal care, and preparing hot meals, were chosen to represent progressively more difficult tasks of independent living. The responses yielded the following estimates:

Frequently or Always Have Difficulty			Frequently or Always Have Difficulty and Receive no Assistance		
House-keeping	Personal care	Cooking	House-keeping	Personal care	Cooking
18.2%	9.7%	10.3%	6.1%	2.5%	2.5%

The two percentages for problems with cooking hot meals (10.3% and 2.5%) were chosen as the best indicators of risk, because being able to cook is vital to daily nutrition and health, and the physical and mental activities involved are basic to independent living. Inability to complete this activity is a significant indicator of advanced frailty, and retaining a person with this level of daily support is beyond the capacity of most independent living facilities even with assistance from visiting service providers.

A measure of those experiencing frequent or constant difficulty and receiving no help, for a very vital task of daily living such as cooking hot meals, yields very stringent and conservative estimates of vulnerability. The 10.3% and 2.5% estimates are considerably lower than estimates provided by other studies using more liberal measures. The purpose of choosing such stringent measures is so that there is no question that the numbers these percentages generate represent people with genuine vulnerability and support needs.

The percentages generated by the 5,627 responding residents of subsidized housing were considerably below those of the managers and were not used to represent total resident vulnerability. These residents represent only 54% of the total, and nonrespondents are likely to be more functionally and mentally dependent.

The responding Medicaid recipients are just as likely to underrepresent the total Medicaid population at risk of losing their functional independence. Only 43% responded from this sample. However, no alternative comprehensive estimate is available for this group. The following presents a comparison of the Medicaid and subsidized housing results:

	Responding Medicaid Recipients	Responding Residents
Frequently or always have difficulty cooking hot meals	20.4%	6.1%
Frequently or always have difficulty and receive no help cooking hot meals	2.3%	0.6%

These percentages show that the responding Medicaid recipients are more vulnerable than subsidized housing residents. One explanation is that they have significantly lower incomes than do the residents of subsidized housing, and have had a history of sporadic employment due to lack of education, poor health, and/or disabilities. While two-thirds of the Medicaid respondents receive some Social Security (compared to 92% for subsidized housing respondents), 70% require and receive Supplemental Security Income (compared to only 13% for subsidized housing respondents).

SIGNIFICANT SUBGROUP CHARACTERISTICS

Many crosstabulations were conducted to determine the vulnerability and support needs within subgroups of the primary samples and are all presented in the main report. Three crosstabulations with planning and policy implications are presented here dealing with 1) the old old, 2) manager type, and 3) sponsor type.

1) Increasing vulnerability of the old old. The data shows that as residents age they lose significant functional independence and resources. The following statistics for respondents age 85 and older are not expected to be the norm for a development, because older residents who die or are transferred will be replaced by younger tenants. However, all indications are that managers are finding it difficult to successfully transfer frail tenants and are therefore retaining them. This fact, plus a rapidly aging general elderly population and therefore an aging waiting list for subsidized housing, means that some facilities will take on these proportions of vulnerability.

Persons Aged 85+

	Subsidized Housing		Medicaid Recipients	
	Having difficulty	Having difficulty receiving no help	Having difficulty	Having difficulty receiving no help
Housekeeping/ laundry	36.4%	4.4%	61.5%	3.1%
Personal care, bathing, dressing	20.6%	4.7%	52.1%	3.1%
Cooking, getting in and out of bed	15.5%	3.7%	44.8%	4.2%

The old old Medicaid respondents report much higher percentages having difficulty with independent living activities when compared to the subsidized housing respondents. This is because the Medicaid respondents are a poorer and more disabled population. Despite the higher percentage of Medicaid respondents having difficulty with activities, relatively fewer of them receive no help when compared with subsidized housing respondents. This is explained by the fact that the average Medicaid respondent (both over age 85 and younger) live with another adult who can provide assistance (2.1 persons per household), while the average subsidized housing resident lives alone.

2. Management types and resident support services. Managers were grouped into types based on their answers to three groups of management activities--activities related to managing the physical plant, basic tenant oriented activities, and social and support services for the tenants. Seven management types were identified ranging from traditional physical plant orientation (17%) to social/support orientation (19%). The most common (44%), were managers involved in a balanced approach of all three activity types. When these profiles were crosstabulated by the housing sponsor type (public housing, non-IHDA Section 8, and IHDA), it became clear that these manager profiles were not sponsor policy but individual managers' responses to residents' needs or personal interpretations of the job.

3. Retention or transfer patterns by sponsor type. There was a tendency for managers to have similar patterns of

transfer or retention of frail residents by sponsor type, but this was not consistent enough to suggest a sponsor policy on retention or evicton. Rather, it seemed to reflect the type of managers sponsors hired and variations in the financial resources of the tenants. Public housing and non-IHDA Section 8 facilities are represented by more managers who profess an "accommodating" management model--an environment that allows more frail residents to remain in the facility. The IHDA facilities are represented by more managers who profess a "constant" model--attempting through stricter transfer policy to retain the original independent population profile.

INAPPROPRIATE RETENTION OR TRANSFER

An actual case by case evaluation of frail elderly is necessary in order to determine if they are being retained in subsidized housing with insufficient support or being transferred to long-term care institutions when they could remain in independent housing with appropriate assistance. Because this methodology was cost prohibitive, surrogate measures were employed. Three findings combine to suggest that both inappropriate transfers and retentions are common.

The managers were presented with a situation that past research had shown would require transfer or a permanent increase in the on-site support staff and services in order to assure that all frail tenants received proper assistance. The scenario specified that 20% of the residents were facility-bound--unable to shop, cook or complete personal care activities vital to independent living. The managers were then asked what actions would be taken and who would be responsible. Only 25% of the managers said that they would seek to transfer residents at this point. In the case of public housing, 44% of the managers would attempt to retain tenants with visiting homemaker services only. Other managers would rely on multiple visiting services. None relied on the family at this level of dependence and only 2% relied on elderly neighbors and 7% on site staff.

This managerial effort to retain very frail residents may be understandable if there are no viable transfer options, but there is strong evidence that most managers are not prepared to determine adequately what difficulties and support needs their tenants have, let alone be able to retain them with adequate support. Fully 66% of the managers were unable even to estimate the number of their tenants who had the functional limitations and support needs that made them facility-bound.

Inappropriate transfers are also very likely. First, of all the resident moves to more dependent care in the previous years, managers report that 24% were to relatives and friends, 15% to private residences, 3% to congregate housing, and 58% to nursing homes. Again, the fact that 66% of the managers did not know the functional disabilities of their residents brings into question their ability to conduct accurate assessments for transfer. More importantly, only 5% of the managers had a formal professional assessment committee in place to handle transfers. Finally, there is strong evidence that there are few appropriate places to transfer subsidized housing residents.

Transfer to the family is often not a viable alternative, as many of these elderly are living in subsidized housing because housing support from their family is nonexistent or inappropriate. These elderly also lack the resources necessary to afford a move to private pay congregate housing or other independent housing facility with a service-rich support staff. There are fewer than ten such facilities with rent subsidies in the entire state of Illinois.

PROPOSED SOLUTIONS

Three policy/program alternatives are explored: 1) a laissez-faire approach; 2) development of an explicit sponsor policy on transfer/retention and provision of the staff training and visiting service coordination necessary to achieve the policy; 3) conversion of some or all facilities to subsidized congregate housing to allow residents to age-in-place or construction of new subsidized congregate housing.

1. A Laissez-Faire Approach

Because of general welfare cutbacks in recent years, some gerontologists now see residence in subsidized housing as far more advantageous than residence in conventional housing even for frail elderly. Some argue that we must prioritize the limited public resources available to frail elderly who have no site manager, maintenance staff, security system, or elderly neighbors who can work together to cope with increasing frailty.

This approach makes several incorrect assumptions about subsidized housing environments. A laissez-faire approach can seriously affect the well-being of all residents, not just the most frail. Building staff assistance in subsidized housing is minimal because the small staff is confronted with so much support need that they must say no to everyone. This study found that Medicaid respondents living in conventional housing receive more staff assistance (from the custodian) than do subsidized housing respondents. Other studies, specifically focused on help from the neighbors in subsidized housing, reinforce what is reported in this study. That is, as persons become more frail, support from neighbors declines. In effect there is far less support found in subsidized housing than is commonly assumed. Allowing the population in subsidized housing to age-in-place without doing anything can actually increase the stress on all caregivers (family, neighbors, and staff) and can negatively affect the morale of the entire population. A growing mismatch between environmental capacity and tenant competence can reduce tenant abilities to care for themselves, thus increasing the size of the population at risk.

2. Sponsor Policy, Site Staff Training, and Support Service Coordination

At a very minimum, subsidized housing sponsors must develop clear policy on what disabilities their facility can accommodate, on termination criteria and procedures to monitor resident independence, and on staff responsibilities. If necessary, site managers may have to be retrained or replaced to develop a staff capable of performing the activities involved in managing an aging population.

When clear policy is in place, the entire support network including residents, family, staff, and visiting community agencies must be evaluated and coordinated to provide the most unobtrusive, efficient, appropriate and comprehensive service possible within each provider's limitations. These limitations must be clearly understood so that realistic policies are established. A key to support care is minimizing stress and confusion, allowing the independent lifestyle of the residents to prevail, and eliminating both overcaring and undercaring.

3. Conversion to Congregate Housing to Fully Accommodate an Aging Population

Congregate housing can be defined as assisted independent living with a minimum of five hot meals per week and housekeeping services. It can include more communal meals and personal care aid, but it includes no skilled care. The congregate model has been called the most appropriate environment for most elderly even if they do not partake of all the services, because it allows all residents to live functionally independent lives without stressful, debilitating, and potentially inappropriate transfers. Fully 69% of the subsidized housing respondents preferred this model over moves to family or friends (17%), nursing homes (9%), or other settings (6%) if advancing disabilities forced them to move. Three of the 64 facilities sampled have already been converted to congregate housing and two others have partial conversions (8%).

Most of the facilities in the sample (70-80%) have the physical amenities necessary to convert to congregate housing with minimal capital expenses. In these cases the primary costs are for congregate housing services: dining room furniture, food serving equipment, the cost of catering the meals, and the cost of housekeeping staff. Currently there is both a congressional inquiry and a national lobbying effort to develop a 50/50 state/federal formula to fund a congregate housing services program (CHSP). At least seven states already have a congregate housing program or are preparing legislation for a program.

Conversion could be incremental, using an accommodation model and adding staff as needed to meet new resident support needs after an initial threshold of residents requiring congregate services was identified. Another strategy is to designate a number of facilities for congregate housing and fully convert them to serve a regional need. The second scheme has the disadvantage of requiring transfers, but is likely to make the conversion process more cost efficient. Neither alternative addresses the growing need for new congregate housing within the larger community. Many Medicaid respondents also require assisted independent living environments.

DEMAND FOR CONGREGATE HOUSING FACILITIES

Of the three policy alternatives, a laissez-faire approach will only exacerbate the problems caused by aging populations living in subsidized housing for the elderly. Development of clear and consistent retention/transfer policy and accompanying support services is one appropriate policy response. However, any policy no matter how clear and consistent that attempts to maintain an independent population using strict transfer criteria will not prevent the pressure on site staff to retain frail tenants. This is because there are not enough appropriate transfer points for frail and low-income elderly. Only a policy that extends independent subsidized housing to allow frail tenants to age-in-place can assure appropriate retention and postpone transfer to a time when dependent care is truly needed.

Conversion to congregate housing is the most logical extension of independent group living that allows tenants to age-in-place. If we assume that the 10.3% vulnerable elderly identified by managers in the 25% sample represent the need for congregate housing conversion, approximatly 4,400 subsidized elderly housing units must be converted in the 23 metropolitan counties of Illinois. Making a similar assumption for the 20.4% vulnerable Medicaid respondents suggests that 7,000 units of newly constructed, low-income congregate housing for the elderly are needed.

ROBERT A. BORSKI
3D DISTRICT, PENNSYLVANIA

COMMITTEES
MERCHANT MARINE
AND FISHERIES
PUBLIC WORKS
AND TRANSPORTATION
SELECT COMMITTEE ON AGING

Congress of the United States
House of Representatives
Washington, DC

PLEASE REPLY TO:
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WASHINGTON, DC 20515
(202) 225-8251
☐ 7137 FRANKFORD AVENUE
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(215) 335-3355

August 4, 1989

Honorable Edward Roybal
Chairman
House Select Committee on Aging
710 House Annex #1
Washington, D.C. 20515

Dear Mr. Chairman:

I have enclosed a copy of testimony which I would like to submit for the record of the July 26, 1989 hearing on Housing for the Elderly.

My constituent, Ephraim Goldstein, has been involved in the development and administration of elderly housing since 1970. I believe his insight and expertise will prove very valuable to the Committee in its continuing examination of the elderly housing problem.

Thank you for your consideration in this matter. Should you need further information, please don't hesitate to contact me or Mary McSorley of my staff.

Sincerely,

Bob Borski

ROBERT A. BORSKI
Member of Congress

RAB:mtm
Enclosure

STATEMENT OF EPHRAIM F. GOLDSTEIN
EXECUTIVE VICE PRESIDENT
FEDERATION HOUSING, INC.
TO THE
HOUSE SELECT COMMITTEE ON AGING
AUGUST 2, 1989

Mr. Chairman:

As one who has been involved professionally, since 1970, in developing housing for the elderly, I am deeply grateful to Congressman Robert Borski for inviting me to present testimony in support of legislation that provides the elderly with a comprehensive program of housing and ancillary services in support of their continued independence.

Since the need for such housing has been more than adequately substantiated, I will not dwell on the staggering numbers of our growing older adult population and the lack of adequate housing options within the financial means of those in the lower income levels. I wish, instead, to cite some specific problems which I hope your committee will take into consideration. In light of the diminution of H.U.D.'s appropriated dollars to create such housing in recent years, I am particularly encouraged by Secretary Jack Kemp's statement to your committee on July 26th, in which he recognizes not only the need for housing the well, independent older adult, but also the more vulnerable, frail older adults who wish to continue living in the mainstream of society.

His well-documented argument for the creation of additional housing for the independent elderly poor and the frail elderly bears directly on key elements of this issue, but fails to consider several significant problems which sponsors and managers of elderly housing face in their day-to-day management of these projects.

As a professional social worker and administrator since 1950, I have been a close observer of the needs of our older adult population and have, under the aegis of Federation Housing, Inc., a non-profit organization, successfully developed four elderly projects, with a total of 771 apartment units for independent elderly with a fifth building, currently under construction, to contain 77 units of congregate housing for the more frail, yet independent, older adult. With no publicity other than a ground-breaking ceremony and a sign at the construction site, over 400 requests for applications for this building have been received. In addition, Federation Housing has a current waiting list of over 800 applicants for its existing buildings. In an informal survey of similar elderly projects within the City of Philadelphia, I have determined that among 9 projects reporting, there are 5,975 applicants on their current waiting list. This, I believe, is the tip of the iceberg, reflecting only those who persist in keeping their applications on file. There are many who drop off or fail to apply, frustrated over the length of the waiting period as well as the absence of amenities to meet their needs for assistance in daily living.

Statement of Ephraim F. Goldstein
Executive Vice President
Federation Housing, Inc.

Recently, I convened a conference for the managers and agents within H.U.D.'s Region III, dealing with the "Aging-in-Place" phenomenon. The response to this conference, in which Mary Hanlon of your staff was an active participant, was overwhelming. It raised the level of understanding of the H.U.D. personnel who participated, pointing up the need for increased sharing between H.U.D. staff and administrators and the constituency they serve, i.e., the managers, agents and the elderly residents. Moreover, the conference highlighted additional issues that must be addressed as follows:

1. **The Environment:**

As residents and those on the waiting lists age in place, several problems emerge which impact directly on the housing setting. As the population grows older and more frail, its indigenous leadership is diluted, reducing the residents' ability to sustain an ongoing program, thereby placing increased responsibility on management staff to initiate and conduct activities to keep the residents involved.

Applicants who are physically and mentally alert and independent, upon visiting the building, often view the setting with disfavor and tend to be discouraged about entering.

Housekeeping problems, resulting from the perpetuation of an increasingly older population, include increased infestation, replacement of stained carpets and furniture, increased security problems as well as increased numbers of routine and emergency calls such as lock-outs, lost keys, emergency cords pulled in error, ambulance calls for illness and adjustments to the thermostat or window shades. These issues, aside from adding to the burdens of staff, create an atmosphere which is depressing to those residents who are still functioning independently.

Maintaining the integrity of the chronological waiting list, where applicants have been waiting for years, results in the admission of older residents, exacerbating the problem. The need to introduce some younger, more vibrant residents into the project to balance the population and to provide for some indigenous leadership is thwarted by the inflexibility of this admission policy. While it may be fair to the applicants, it is detrimental to the project.

Existing law requires that the Section 202 program serve only the **very low income** elderly; the previously designated **low income** group (whose income is somewhat higher, has been eliminated from eligibility. This regulation creates a social climate within the housing facility that isolates these people from other socio-economic groups. It limits the Residents' Association's financial ability and the availability of potential leadership that could be provided by those representing the low income group. I would recommend that the "low income" eligibility be re-instituted, to provide for a more evenly balanced socio-economic environment and at the same time reduce the Section 8 rent subsidy requirements for the project. It would also provide a source of more able residents, capable of sustaining some leadership qualities not often found among the very low income elderly.

Another factor which adversely affects the housing environment is the unisex character of the population. Aside from the small male presence among the couples occupying elderly housing, the facility is predominantly female. To provide for a more balanced and socially desirable atmosphere, it is hoped that there can be some flexibility in giving male applicants some preferential consideration.

These approaches would provide for greater opportunities for mutual self-help within the resident population, a reduction in the Section 8 subsidy for those residents in the "low income" category and would enhance the lives and the atmosphere of the project.

2. **Independent vs. Congregate Facilities**

While it is essential to recognize the need for congregate services to accommodate frail older adults, let us not convert the independent housing environments, which were created to serve the more self-reliant elderly group, into quasi-nursing homes. The progression of frailties is an ongoing process which must be faced realistically and, as service needs increase, unless there are available reasonably priced nursing homes, independent housing modified to become congregate housing will soon become equivalent to a nursing home, requiring licensure to adequately accommodate the remaining population. It is essential that the independent housing stock remain independent; that additional units be created to meet the increasing aging population and that congregate housing units be funded adequately to meet this growing need.

3. **Non-Elderly Handicapped**

Within the projects that I oversee, the cultural and social needs of the elderly appear incompatible with those of our younger handicapped residents, creating serious social conflicts within our buildings. Hard rock music, late night

Statement of Ephraim F. Goldstein
Executive Vice President
Federation Housing, Inc.

parties and other patterns of behavior do not create a hospitable atmosphere for elderly occupying the same premises, resulting in conflicts, in which management must periodically intervene.

Sponsors of elderly housing should not be required to provide the variety of supportive services which fall outside the scope of its housing program to non-elderly handicapped persons who may need a variety of services and oversight for their own protection as well as for the safety and general welfare of the housing population. Recent additional appropriations specifically earmarked for developmentally disabled and mentally handicapped persons are an obvious attempt by the administration to serve the pressing needs of these handicapped people; recognizing their special need for housing in settings that can provide them the amenities that are vital to their ability to live in the community. H.U.D. has designated a portion of the 202 funds for such housing, apart from the funding to be made available for elderly housing. This is a step in the right direction.

As the result of the release from mental hospitals and other institutions which have housed people with chronic organic brain syndrome, psychosis and other mental disabilities, these handicapped persons have been applying in greater and greater numbers for housing in section 202, 236 and 231 facilities that have been accommodating the elderly. It is anticipated that the continuing influx of such individuals will serve as a deterrent for normal older adult admissions, eventuating in these facilities becoming institutional in character.

The continuing infusion of such handicapped individuals into elderly housing projects significantly increases the service requirements of management that is ill-equipped to provide such service and for which funds are not available.

A separation of housing options for the handicapped, to meet their specific needs, should be considered; should not be combined with elderly housing appropriations.

4. Cost Containment

The concept of cost containment in the development of new projects for the elderly has been overemphasized to the point that diminishes the objective of providing a wholesome housing environment for this population group. Adequate community spaces are essential if we are to prevent isolation and to encourage socialization among our residents. To provide a meal service in a congregate housing setting for older adults, it is essential that there be a dining room, yet such a "luxury" was rejected by H.U.D. personnel in the design plans for our congregate facility which is presently under construction. The lack of a specific dining room area creates a work-intensive task for management to accommodate a meal service and provide for other social activities in the same social room. It requires the setting up and dismantling of furniture on a daily basis, adding to the operating costs for personnel, as well as more frequent replacement costs of the furniture. Cost containment, without a clear understanding and appreciation of the implications of specific restrictions, merely introduces barriers to the elderly in their daily living. The lobbies of elderly housing projects serve a vital vehicle for opportunities for informal socialization, for people watching (which often serves as a pastime for older adults, getting them out of their apartment and enabling management to make contact with them and to engage them in the flow of activities).

The reduction of the number of units approvable for funding creates an inefficient and not at all cost-effective project when the project requires essentially the same staff to handle 70 units as it does to operate 100 units.

5. Case Management

Federation Housing employs two full time professional social workers whose responsibilities entail direct contact with residents, providing linkages as they are needed to a variety of community supportive services. They also work with the Residents' Associations of each project, developing indigenous leadership and assisting them in the planning and implementation of a variety of programs and activities. As Secretary Kemp has previously noted, this kind of supportive service is essential to foster a meaningful, enriching environment for the residents. The funding of such services should be included in the operating budgets of elderly housing projects; not relying upon the good will and fund raising abilities of the non-profit sponsoring organization.

6. Annual Section 202 Competition

Each year there are a number of applications for Section 202 funding which are found approvable but which are unfunded because of limited appropriations. The preparation of these applications and the Review process requires extensive work and time and is costly to both the Sponsor and H.U.D. Moreover, a number of projects which receive approval for funding do not get off the drawing board for a variety of reasons. I feel that the Sponsors of approvable, unfunded applications should not need to resubmit their proposals anew year after year but, rather, update any exhibits which may reflect new circumstances. This would save both their time and effort as well as that of H.U.D. personnel who must review these applications. Moreover, these renewed applications should be given preferential consideration before new applications; getting into the pipeline faster, thereby producing more housing expeditiously.

I appreciate this opportunity to offer these comments and suggestions and look forward to increased federal support from the administration and from our legislative bodies to meet the challenges of unmet needs for increasing the housing supply and service components for the growing number of independent elderly, the frail and the handicapped.

Number of Current Applicants
In Local Non-profit Elderly Housing Projects
Philadelphia

Name of Project	Couples	Singles	Handicaps Under 62	TOTAL
Casa Enrico Fermi Apts.	2	144	4	150
Four Freedoms House	28	231	-	259
Holy Redeemer Village	150	1,050	6 Over 62-35	1,200
Opportunities For Aging Housing Corp.				
Tower I	0	500	0	500
Tower II	10	357	25 Over 62-308	700
Washington Square West	13	98	2	113
Downingtown Sr. Citizens	8	39	0	47
University Square Apt. Complex For Senior Citizens	500	1,400	600	2,500
Clara Baldwin Manor	7	193	0	200
Gloria DeiTowers	56	250	0	306
				5,975

FLOOR STATEMENT OF JAMES J. FLORIO

INTRODUCTION OF THE

"REVERSE MORTGAGE INSURANCE FOR OLDER AMERICANS ACT OF 1989"

Mr. Speaker, as Chairman of the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging, I am pleased today to introduce a bill which will help older Americans remain in their homes while at the same time benefitting from the equity that they have built up in those homes. My legislation, the "Reverse Mortgage Insurance for Older Americans Act of 1989," would expand and improve the five year home equity conversion demonstration that Congress authorized in the Housing and Community Development Act of 1987. This legislation will also strengthen the consumer protection provisions in the current program.

Mr. Speaker, I am honored to have my distinguished colleague from the third district of New Jersey, Representative Frank Pallone, Jr., join me as an original cosponsor of this legislation to assist older Americans. Last February, we conducted a hearing of the Select Committee on Aging in Toms River, New Jersey, and we heard excellent testimony on a number of subjects including home equity conversion. This bill is in part a result of that hearing, and I appreciate my colleague's support.

The current "Home Equity Conversion Mortgage Insurance Demonstration" program, which is administered by the Department of Housing and Urban Development, will insure 2500 reverse mortgages. The mortgages are available to homeowners who are 62 years of age and older and have little or no mortgage debt remaining on their property. The demonstration, which is authorized through September 1991, enables elderly homeowners to convert the equity in their homes into cash. The Federal Housing Administration (FHA) insures the reverse mortgages and protects both the lenders and the homeowners against risks such as default and eviction.

A reverse mortgage operates in the opposite way from a forward mortgage. Rather than borrowing a lump sum to buy a house and repaying it monthly (forward mortgage), the homeowners instead receive monthly advances based on their home equity. The repayment plus interest will be paid in the form of a lump sum at a future date -- when the borrower dies, sells the house, or upon reaching a previously agreed to date. This arrangement allows homeowners to receive a stream of income based on the accumulated equity in their homes.

Mr. Speaker, before I describe the specific provisions in the "Reverse Mortgage Insurance for Older Americans Act of 1989," I would like to explain why these changes are needed. To begin, one must understand the enormous resources that many Americans have invested in their homes. It is estimated that there is $630 billion of equity tied up in the houses of people 65 years of age and older, and that by 1990, that figure will increase to $750 billion. These facts have created a strong interest in developing financial arrangements to allow access to this equity.

Homes are the most commonly held and most valuable assets that older Americans possess; three out of four elderly persons own their own homes. It is estimated that 80 percent of these homeowners do not have a mortgage. However, despite the value of home equity held by the elderly, six out of every ten of these homeowners are low-income or very low-income. When older Americans are house-rich but cash-poor, the demands of property taxes, insurance, home repairs, utilities, and health care can become overwhelming.

Many older homeowners find it impossible to keep up with the cost of living and are forced to sell the home that they worked most of their lives to obtain. Needless to say, there is a great need for reverse mortgage options, and it was a significant step forward when Congress authorized the demonstration in 1987.

Mr. Speaker, my legislation will make a number of straightforward changes in the current law to improve the demonstration program. When Congress developed the demonstration in 1987, we underestimated the need for insured reverse mortgages and the interest from both lenders and homeowners that the demonstration would create. Although the 2500 insured reverse mortgages became available only yesterday, there are many financial institutions that would like to offer these mortgages but were not selected in the lottery that HUD conducted from the large number of applicants. In addition, over 12,000 interested homeowners have contacted HUD regarding this limited program.

I believe that we must expand substantially the number of reverse mortgages that will be available over the next three years in order to clearly demonstrate the demand for reverse mortgages, the types of arrangements selected by homeowners, and the long-term benefits of such arrangements. After consultation with the National Center for Home Equity Conversion and the American Association of Retired Persons, I propose increasing the number of available insured reverse mortgages under the mortgage insurance demonstration from 2500 to 25,000.

It is important to note that the cost of increasing the number of reverse mortgages will not be significant because the FHA insurance is financed through the premiums that each homeowner pays to the FHA or the lending institution.

Mr. Speaker, the bill that I am introducing today makes several other changes to strengthen the program. It modifies the maximum value of the home that may be used to determine payments to the borrower. In order to make the demonstration more helpful to persons living in areas with high housing costs, the legislation bases the maximum amount of equity that may be converted into income at the greater of 95 percent of the median 1-family house price in the United States or in the particular area where the house is located. This approach replaces the provision that tied the maximum amount allowed to be converted to the maximum amount that FHA insures for single-family home mortgages. There is little reason to tie these programs together.

Next, the bill clarifies that each financial institution offering reverse mortgages must offer to the homeowner (mortgagor) a full range of reverse mortgage options. These methods include the following: line-of-credit, monthly payments over a term specified by the mortgage, a combination of monthly payments and a line-of-credit, monthly payments over the tenure of the mortgage, and a combination of both monthly payments over the tenure of the mortgage and a line-of-credit. This provision will ensure that these options are available to homeowners and will enable Congress to make a better evaluation of the demand for the different types of reverse mortgage methods. If homeowners are not offered all of these methods, we will not be able to know if they wanted them.

Mr. Speaker, this legislation also allows the mortgagor to switch from one type of reverse mortgage to another during the course of the mortgage. This change does not affect the soundness of the mortgages, and allows some flexibility for the older person and his or her family.

The bill also clarifies a very important point for older homeowners across the Nation. It states that a homeowner may conserve part of the accumulated equity in the home. This means, for example, that a single, 70 year old woman entering into a reverse mortgage could elect to set aside a portion of her equity to be used for future needs, such as health care, if she needs to leave the home and sell it at a future date. She could also elect to conserve a portion of the equity to be left to her children.

Once again, this does not affect the soundness of the mortgage. If the homeowner chooses to conserve some of the equity, that amount is not calculated into the reverse mortgage for the purpose of monthly payments and interest.

Mr. Speaker, the last section of my bill addresses several issues relating to protecting the older consumer of these reverse mortgages. There is currently some confusion as to how lenders must describe the limits of the mortgagors' liability under reverse mortgages. This bill states that the lender must explain that under a reverse mortgage there are definite limitations on the liability that the homeowner is assuming. Further, the legislation states that the lender must provide to the homeowner, prior to closing, a statement of the projected total cost of the mortgage to the homeowner. This information must be provided as a single annual average interest rate under at least two different appreciation rates for not less than two projected loan terms.

This provision will ensure that lenders provide a clear picture of the cost of reverse mortgages to consumers, with little administrative burden to financial institutions offering such mortgages.

Mr. Speaker, the Subcommittee on Housing and Consumer Interests has a long history of support for home equity conversion for older Americans. I believe home equity conversion is an excellent way of improving the quality of life for many seniors who might be forced to move from their homes without such options. The legislation I am introducing today simply expands and improves the good work that Congress did when it passed the "Home Equity Conversion Mortgage Insurance Demonstration" two years ago.

I am very pleased to state that the National Center for Home Equity Conversion and the American Association of Retired Persons have endorsed this legislation. Also, it is important to note that both the Federal National Mortgage Association ("Fannie Mae") and the Federal Home Loan Mortgage Corporation ("Freddie Mac"), who plan to purchase the reverse mortgages, have indicated that they believe the demonstration should be expanded to 25,000 to 30,000 reverse mortgages.

Mr. Speaker, I look forward to working with members of the Committee on Banking, Finance and Urban Affairs, particularly the distinguished Chairman Mr. Gonzalez, to expand and improve this important program.

Jim J Florio
(Original signature of Member)

101st CONGRESS
1st SESSION

H.R. ....

HLC

To amend the National Housing Act to expand the demonstration program of insurance of home equity conversion mortgages for elderly homeowners.

IN THE HOUSE OF REPRESENTATIVES

__________, 19___

Mr. FLORIO introduced the following bill; which was referred to the Committee on __________________

original cosponsor Frank Pallone, Jr.

A BILL

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, SECTION 1. SHORT TITLE.

This Act may be cited as the ``Reverse Mortgage Insurance for Older Americans Act of 1989''.

SEC. 2. LIMITATION ON INSURANCE AUTHORITY AND MAXIMUM AMOUNT INSURED.

Section 255(g) of the National Housing Act (12 U.S.C. 1715z-20(g)) is amended by striking the second and third sentences and inserting the following: ``The total number of mortgages insured under this section may not exceed 25,000. In no case may the benefits of insurance under this section exceed the greater of 95 percent of the median 1-family house price in the United States or 95 percent of the median 1-family house price in the area, as determined by the Secretary.''.

SEC. 3. TYPES OF LOANS.

Section 255(d) of the National Housing Act (12 U.S.C. 1715z-20(d)) is amended--

(1) in paragraph (7), by striking ``and'' at the end;

(2) in paragraph (8), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

``(9) provide for future payments to the mortgagor based on accumulated equity (minus any applicable fees and charges), according to the method that the mortgagor shall select from among the methods under this pargraph, by payment of the amount--

``(A) based upon a line-of-credit;

``(B) on a monthly basis over a term specified by the mortgagor;

``(C) on a monthly basis over a term specified by the mortgagor and based upon a line-of-credit;

``(D) on a monthly basis over the tenure of the mortgagor;

``(E) on a monthly basis over the tenure of the mortgagor and based upon a line of credit; or

``(F) on any other basis that the Secretary considers appropriate; and

``(10) provide that the mortgagor may convert the method of payment under paragraph (9) to any other method during the term of the mortgage.''.

SEC. 4. LIMITATION ON LIABILITY OF MORTGAGOR.

Section 255(d)(7) of the National Housing Act (12 U.S.C. 1715z-20(d)(7)) is amended by striking subparagraph (A) and inserting the following new subparagraph:

``(A) the net sales proceeds from the dwelling that are subject to the mortgage (based upon the amount of the accumulated equity retained by the mortgagor to be subject to the mortgage, as agreed upon by the mortgagor and mortgagee); or''.

SEC. 5. DISCLOSURES BY MORTGAGEE REGARDING LIABILITY OF

FLORIO100

MORTGAGOR.

Section 255(e) of the National Housing Act (12 U.S.C. 1715z-20(e)) is amended--

(1) in paragraph (2)--

(A) by inserting after ``statement'' the following: ``informing the homeowner that the liability of the homeowner under the mortgage is limited and''; and

(B) by striking ``and'' at the end;

(2) in paragraph (3), by striking the period at the end and inserting ``; and''; and

(3) by adding at the end the following new paragraph:

``(4) prior to loan closing, a statement of the projected total cost of the mortgage to the homeowner based on the projected total future loan balance (such cost expressed as a single average annual interest rate for at least 2 different appreciation rates for the term of the mortgage) for not less than 2 projected loan terms, as the Secretary shall determine, which shall include--

``(A) the cost for a short-term mortgage; and

``(B) the cost for a loan term equaling the actuarial life expectancy of the mortgagor.''.